MISTAKEN AND UNRECOVERED MEDICARE PAYMENTS

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

FEBRUARY 26, 1991

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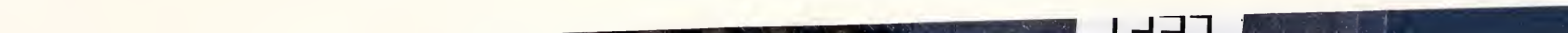

MISTAKEN AND UNRECOVERED MEDICARE PAYMENTS

TUESDAY, FEBRUARY 26, 1991

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON OVERSIGHT,
Washington, DC.

The committee met, pursuant to call, at 9:30 a.m. in room 1100, Longworth House Office Building, Hon. J.J. Pickle (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
WEDNESDAY, FEBRUARY 20, 1991

PRESS RELEASE #2
SUBCOMMITTEE ON OVERSIGHT
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1105 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
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THE HONORABLE J. J. PICKLE (D., TEXAS), CHAIRMAN,
SUBCOMMITTEE ON OVERSIGHT, COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING ON MISTAKEN AND UNRECOVERED MEDICARE PAYMENTS

The Honorable J. J. Pickle (D., Texas), Chairman of the Subcommittee on Oversight, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on mistaken and unrecovered Medicare payments. This hearing is being conducted as part of the Chairman Rostenkowski's major oversight initiative for the 102nd Congress focusing on efficiency and policy effectiveness of programs in the Committee's jurisdiction. The hearing will be held on Tuesday, February 26, 1991, beginning at 9:30 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

Under present law, Medicare is a secondary payer under specified circumstances when Medicare beneficiaries are covered by other insurance. Under the Medicare Secondary Payer (MSP) provisions, Medicare is secondary to certain employer group health plans for items and services provided to aged, disabled and end-stage renal disease beneficiaries. Medicare is also secondary to automobile, no-fault and liability insurance. The largest group of claims subject to the MSP provisions are those made by Medicare beneficiaries (or their spouses) who continue to work after age 65 and who receive health insurance coverage through an employer group health plan.

Situations in which Medicare is the secondary payer are identified through beneficiary questionnaires; provider identification of third-party coverage; Medicare contractor screening; data collection and exchange; and data transfers with government agencies. In addition, the Health Care Finance Administration (HCFA) will soon complete its first data match of Social Security Administration and Internal Revenue Service records. This match is intended to identify additional Medicare beneficiaries (and spouses of beneficiaries) covered by employer group health insurance plans.

In implementing the MSP provisions, HCFA has given priority to Medicare contractors' pre-payment efforts to identify other primary insurance at the time a beneficiary submits the first Medicare claim. Contractors' post-payment efforts to identify, track down, and recover for claims that the government has already paid out, have received less attention. The Department of Health and Human Services has estimated that the annual amount Medicare has paid, which under MSP rules should have been paid by other insurance, has run as high as $1 billion. A recent survey by HCFA of Medicare contractors reveals widespread disparities in the number of erroneous Medicare payments and contractor efforts to identify and recover overpayments for the Federal Government.

The exact magnitude of this recovery problem, nationwide, remains somewhat unclear; however, a recent report by the General Accounting Office (GAO) illustrates the situation involving one contractor. The GAO report identifies and analyzes some 3,059 cases of claims (totaling $8.8 million) paid by the Maryland Medicare contractor, Blue Cross and Blue Shield of Maryland, for which private insurers had been identified as having primary payment responsibility. In 229 of these cases, the erroneous Medicare payments totalled more than $10,000 each. The GAO reports that, in more than 1,500 of these cases, Blue Cross and Blue Shield of Maryland, itself, has been identified as the primary payer. When GAO first began its analysis of the Maryland claims, Blue Cross and Blue Shield was taking no action to recover erroneous payments, either from itself or from other insurers. The GAO is in the process of investigating the problem elsewhere, and will present testimony about its preliminary findings with regard to Medicare contractors in Arizona, Nevada, California, Pennsylvania and Florida.

(MORE)

In announcing the hearing, Chairman Pickle stated: "With our Federal budget deficit problems, it's becoming increasingly important that Congress look for ways to eliminate waste in our Federal benefit programs. What we see taking place at the Maryland Medicare contractor is a situation where the Federal Government has been paying bills that the private insurance should be paying. There is an opportunity here to make real savings for the Medicare program.

"The Maryland contractor's failure to recover mistaken Medicare payments appears to be symptomatic of a broader problem. Nationwide, backlogs of unrecovered Medicare claims will undoubtedly become worse when the Internal Revenue Service/Social Security Administration data match identifies even more mistaken payments. Further, once a Medicare contractor becomes aware of a mistaken payment, the time for recovery is limited. Unless the Medicare contractors are prepared to handle these Medicare recovery cases in a timely manner, the potential savings that could be realized from the data match will be lost."

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Because the oral testimony at the hearing will be presented by invited witnesses only, interested parties are encouraged to provide written statements for the printed hearing record. Persons submitting written comments for the printed record of the hearing should submit six (6) copies by the close of business, Friday, March 15, 1991, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, room 1102 Longworth House Office Building, Washington, D.C. 20515.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

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Chairman PICKLE. The Chair will ask the subcommittee to please come to order. Will our guests please take a seat so we may move forward.

Earlier this month the Subcommittee on Oversight held a hearing on the problem of Federal benefit payments to deceased persons. Today, the subcommittee is, once again, concerned with benefit payments the Federal Government should not be making. The payments we focus on today are not, however, payments to ineligible or nonliving people. Instead, they are payments that should have been made by someone other than the Federal Government. In short, today we will focus on a situation where the Federal Government has been erroneously paying someone else's bills.

Today's hearing focuses on the Medicare secondary payer provisions, usually referred to as "MSP." The MSP provisions make Medicare the secondary payer for certain classes of Medicare beneficiaries who have other insurance, most commonly employer-sponsored group health insurance. If other insurance is primary, Medicare is responsible only for services not covered under the primary insurance policy.

Since enactment of the MSP provisions, Medicare contractors have had a real problem identifying erroneously paid claims for which an employer group health plan is primary. The Department of Health and Human Services has estimated that there may be an additional $1 billion annually in potential secondary payments that are currently unidentified. Identification has been especially difficult in the case of a beneficiary covered under a spouse's employer group health plan.

To help in the identification of these claims, hospitals are required to ask beneficiaries whether they or their spouse work and, if so, whether they have health insurance. Doctors have been encouraged to ask similar questions. In addition, Medicare contractors contact beneficiaries when they file their first Medicare claim to determine if there is other primary insurance.

These efforts to identify MSP situations early on reflect the importance the Health Care Financing Administration attaches to the identification of primary insurance at the front end, before a claim is paid. Still, thousands of claims, involving hundreds of millions of dollars, have slipped through the system and have been paid erroneously. For these claims, the contractors must chase down the insurance company, literally speaking, that should have paid the claim or seek recovery from the hospital that erroneously billed Medicare. It appears that many contractors have backlogs of these mistakenly paid claims that they are not attempting to recover.

While it is impossible to state precisely the total dollar value nationwide of the claims erroneously paid by Medicare contractors, the General Accounting Office recently completed a report analyzing the unrecovered claims at one Medicare contractor. At Blue Cross and Blue Shield of Maryland, $8.8 million in claims were identified as Medicare payments that should have been paid by other insurance companies. Today we will hear testimony about these cases and receive GAO's testimony about its ongoing examinations of other contractors.

I believe this hearing is especially timely. Later this year, the Health Care Financing Administration will complete a data match

of Internal Revenue Service and Social Security Administration records. This data match will identify Medicare beneficiaries who were employed during the years 1987 to 1989 and who had primary insurance under an employer plan. This information will make it possible to identify even more Medicare claims that were paid erroneously. If contractors are having problems seeking recoveries now, I am concerned that the situation will only get worse once the data match is completed. I would like at some point, those from HCFA, to know when that data match study will be completed, when we will get that information, but I will get that during your testimony.

At the hearing today, we intend to explore what Congress and the administration should do to stop these erroneous Medicare payments and to ensure that primary insurance companies pay the bills. It is a hard issue with no easy solution, but I want to make sure that HCFA knows that we, this committee, believe that the MSP provisions are a high priority. Something must be done, and the witnesses before us today must assist us in guiding the subcommittee toward a workable solution. That completes my opening statement.

I want to ask Mr. Schulze now if he has any statement to make at this time. Mr. Schulze.

Mr. SCHULZE. Thank you, Mr. Chairman.

Today's hearing focuses on problems in one part of the Medicare program, the Medicare secondary payer program, or what we commonly called MSP. I want to commend you, Mr. Chairman, for keeping oversight of the Medicare program at the top of the committee's agenda. In an era when all health care costs are escalating at an alarming rate, we owe it to the beneficiaries to do everything we can to root out any waste and mismanagement in the Medicare system.

I am particularly pleased with your desire to hold additional field hearings on Medicare issues, especially instances of fraud and abuse. The MSP program involves primarily the working elderly, people who are over 65 but who are still employed and have health insurance through their employer.

In theory, the idea behind MSP is simple, make certain other forms of health coverage pay first, and then Medicare picks up the rest of the tab. MSP, if properly implemented, holds the potential for literally billions in savings to Medicare, savings that could help keep the level of the copayments and deductibles as low as possible. However, in practice the Government is estimated to lose up to $1 billion each year in erroneous payments.

In many cases, this is money that has been identified and is ripe for the picking. It seems to me that whether it is a bank calling it a note, credit card companies sending past due notices, or a program like MSP the process is basically the same, identify who owes you the money, then go out and collect it.

Today we will hear about problems in both areas. First, there are problems in identifying just which beneficiaries have other primary health coverage. Hospitals and physicians are asked to screen patients for other health coverage and then submit claims to the right insurance carrier. However, we will hear that there is really no incentive in the system for them to do so. Even when other pri-

mary health care coverage is identified, the carriers don't do a good job in collecting what is owed.

We will hear how a Maryland Medicare contractor let $8.8 million in potential recoveries sit uncollected. What is even worse, almost half of that money was owed by the contractor's private health insurance counterpart.

It is no wonder that contractors nationwide have refused to cross-check their internal records. To be fair, Medicare contractors face a catch-22 situation when they do take claims off line in order to investigate whether other insurance coverage applies. There is nothing like the wrath of a Congressman calling to see why the benefit checks have been delayed. There has to be a way to provide for both prompt and correct payment on Medicare claims.

Finally, we in Congress have to get our act together to improve MSP enforcement. Despite the recent budget summit, current budget score keeping rules prevent MSP savings from being properly counted. While I am the first one to speak out against waste and excessive Government spending, we must carefully review the funding for a program with a potential to bring in $33 for every $1 spent.

Mr. Chairman, throughout the whole MSP process, we must make sure the beneficiary is not hurt by all the red tape in deciding who should pay. In my mind, the hospitals and doctors should know who to bill first. HCFA and its contractors should know enough to collect the moneys involved.

The beneficiaries should get the break on spiraling Medicare costs. When all is said and done, it is the beneficiary who gets left holding the bag for erroneous Medicare payments.

Chairman PICKLE. I thank you, Mr. Schulze. Mr. Anthony.

Mr. ANTHONY. Thank you, Mr. Chairman. I do have a few comments that I would like to insert in the record. First, welcome, ladies and gentleman before the oversight subcommittee. We look forward to your testimony.

Just a few thoughts: I represent 23 counties in Southern Arkansas. It is a very rural area, and all but one hospital that I represent happens to be classified as a rural hospital. We have had approximately six close in the last 5 years. Throughout the South, and in other rural areas we have had a multitude of hospitals that have closed.

With all of the things that we have done on this committee to try to hold down spiraling health care costs last year, we saw that health care jumped 19 percent, whereas the normal inflation rate was well below that number.

Over the last 10 years, we have had a shrink in Medicare. That means there has been a pressure on all recipients. There have been legislative remedies to try to hold down the Federal cost factor in Medicare, all to the detriment to a large base in this country. In fact, President Bush in his most recent budget has asked for additional Medicare cuts, even in the face of the fact that we made a 5-year deal at the end of last year that we thought would take care of the health care cuts over the next 5 years.

What really bothers me, and the main thing I want this record to reflect and will be the bottom line of all of the questions that I will have for the witnesses today is Chairman Rostenkowski earlier

this year in a press conference with the Washington Post said he would be taking a look at volume in terms of reimbursements to hospitals.

When you mention the word "volume," you have taken a direct shot at small rural hospitals that serve a Medicare population because that is exactly the dynamics of our hospitals. So if we have mismanagement and if we have fraud or if we have other insurance companies that are trying to dump their problems on to the Federal Government. Therefore, we are losing $1 billion of payments that are going out that should not go out, that means there is $1 billion that I can fight for to keep more rural hospitals open when we have this fight later on.

So you can see the viewpoint which I will be coming at you; that is, for every $1 saved in proper management, that is $1 that we will take off the pressure of requiring additional cuts, and when those cuts come, there is no question in my mind that it is going to be my constituents that is going to share an unfair burden of it.

The word has already been let out. The gun has already been loaded, and they have been pointed at my constituency. We are outvoted on this committee and we are outvoted in the Congress, so you can see to a large extent the proper management of your oversight function has a great deal to do with the health care that is going to be delivered to the constituencies that I represent.

Thank you, Mr. Chairman.

Chairman PICKLE. Mr. Sundquist, do you care to make a statement?

Mr. SUNDQUIST. No statement, Mr. Chairman.

Chairman PICKLE. I thank you very much.

Now the Chair is going to ask all of the individuals who will testify this morning to come to the table at one time. I believe you are already perched and ready for action. The reason I have done this is that I would like for each person or each agency to testify, to make a statement, and then we are going to open it up to the subcommittee to ask any or all of you questions and try to pursue this as a group, so that one can respond to the other and just have an informal sort of discussion about the matter.

We recognize the problem. I think you recognize the problem. Now the question is, how do you think we ought to answer this? I ask that question of each one of you. I don't want you to explain just what your role is, but in addition to that I am trying to find out what you think we can do, and this is the approach I think we will take this morning.

Let me also say parenthetically that I want us to analyze this, ask pertinent questions today, make suggestions that we think will be helpful, and then I am going to ask you as a follow through to meet with our subcommittee to see what then can we do. And I want this to be acted on with expedition.

I don't see anything, any reason to drag it out, study it for a year's time. Somewhere between now and April 15, I am going to expect some kind of recommendations to come out from this group. At least, that is our hope and our aim. I wanted you to know that. To do that, we will need your cooperation and your advice and suggestions on it.

Now, the first witness will be Mr. Mike Mangano. Which is Mr. Mangano?

Mr. Mike Mangano is the Deputy Inspector General for Evaluation and Inspections. Then we will hear from Janet Shikles, Director, Health Financing and Policy Issues, accompanied by Terry Davis and Randy Jones. Are they with you?

Mr. Davis and Mr. Jones are backing you up, all right. Then we will hear from Ms. Jill Jacoby, manager of the Medicare secondary payer unit of the Blue Cross and Blue Shield of Maryland. Ms. Jacoby is over here to my right. Then the last witness will be Barbara Gagel, Director of Bureau of Program Operations, HCFA.

Normally, we would be hearing from Barbara Gagel first. I think we will just follow this out and we will then throw it open to questions. If that is agreeable with each of you, we will proceed. I will ask Mr. Michael Mangano if you will present your testimony.

Now I want to ask the subcommittee, let's try to—in order to go through it, each one of you make your statement and we will just go right down the list or whatever order you come. Then we will ask questions. If we start asking a lot of questions now, we can't do that. No Member is prohibited from doing that, of course, but let's see how that can work.

Mr. Mangano.

STATEMENT OF MICHAEL MANGANO, DEPUTY INSPECTOR GENERAL FOR EVALUATION AND INSPECTIONS, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY BOB SIMON, ASSISTANT INSPECTOR GENERAL FOR CRIMINAL INVESTIGATIONS

Mr. MANGANO. Thank you very much, Mr. Chairman.

I am accompanied this morning by Bob Simon, the Assistant Inspector General for Criminal Investigations.

We are here to discuss with you the Medicare secondary payer provisions. I would like to begin by briefly describing the history of the MSP program.

Medicare was established in 1965 to pay for health care services for eligible beneficiaries age 65 or older. For the first 15 years, Medicare was the primary or first payer for all health care claims, except when the claimant was covered by workers compensation, black lung or veterans benefits.

Between 1980 and 1986 Congress passed a series of statutory provisions which established Medicare as a secondary payer to other insurers in certain situations. They include coverage under an automobile, no fault or liability insurance, employer group health plan coverage of beneficiaries who have kidney failure during the first 18 months of Medicare, coverage under an employer group health plan of working beneficiaries age 65 or older or their spouses, and coverage under an employee group health plan provided by an employer of 100,000 or more persons for beneficiaries who are disabled.

Health care providers are required to ask Medicare beneficiaries a series of questions concerning their health insurance coverage. Providers are then required to bill other insurers first when beneficiaries fall within one of the MSP categories described earlier.

Medicare contractors are required to screen all claims for coverage by another insurer. Numerous studies conducted by the Inspector General's Office, the General Accounting Office, and the Health Care Financing Administration have shown that Medicare continues to make mistaken payments as primary payer.

We have conducted 27 separate evaluations and audits concerning MSP since March of 1984. The Health Care Financing Administration has taken a number of actions to improve methods for identifying cases where the primary payment source exists. However, we estimate that more than $600 million was lost to Medicare in mistaken payments in 1988, and recent information suggests that current program losses exceed $1 billion per year.

Chairman PICKLE. Let me interrupt you. Are you reading from your statement or do you have a summary statement?

What are you reading from?

Mr. MANGANO. I am reading portions of the statement to stay within a normal time limit.

Chairman PICKLE. Do we have that statement?

Mr. MANGANO. Yes, you do.

Chairman PICKLE. You are just summarizing the statement?

Mr. MANGANO. Yes, I am.

Chairman PICKLE. All right. Go ahead.

Mr. MANGANO. OK, I would like to briefly describe some of our recent work in this area. We have recently evaluated the procedures used by Medicare carriers to identify primary payment sources. Our study found that the Medicare payers budgets for MSP activities were reduced by 44 percent from 1989 to 1990.

The seven carriers reduced their staff devoted to MSP operations from 127 full-time employees in 1989 to 48 in 1990. Representatives from five of the seven reported that they were not conducting any MSP recovery activities at the time of our review.

Our management advisory report, entitled, "Medicare Secondary Payer: Uncovered Funds," found that while progress has been made in identifying MSP situations, more than $600 million in mistaken Medicare payments were made in 1988.

In March 1990, an OIG report entitled, "More Complete Employer Group Health Plan Information is Needed to Administer the Medicare Secondary Payer Program" identified that HCFA's inability to identify MSP sources before making payments constitutes a material internal control weakness.

In 1988, the OIG published a series of reports covering end stage renal disease, automobile accidents and related claims, and Medicare beneficiaries covered by employee group health plans which documented about $263 million in projected losses to Medicare.

The OIG has conducted five MSP investigations related to suits filed under the Qui Tam provision of the False Claims Act. In each case we recommended that the Government not join the Qui Tam suit, but instead reserve the right to intervene at a later time if appropriate.

In March 1988, we initiated a criminal investigation involving a major health insurance company. This investigation was initiated based on information contained in a law suit filed by a private law firm under the Qui Tam provisions alleging the insurer had defrauded the Medicare program by intentionally paying benefits as

secondary to Medicare when the insurer knew they had primary liability.

The Department of Justice has declined to prosecute this case. However, the Government is pursuing civil recovery against the insurer.

We are currently auditing five Medicare contractors to determine if they are complying with the MSP provisions and to determine the amount of improper Medicare primary payments. These reviews are being conducted at Aetna Insurance Co., Travelers Insurance Co., Empire Blue Cross-Blue Shield, Blue Cross and Blue Shield of Florida, and Blue Cross and Blue Shield of Michigan.

We have made the following recommendations to HCFA to help correct the MSP problems. The Omnibus Budget Reconciliation Act of 1989 provides for an exchange of information between the Internal Revenue Service, Social Security Administration, and HCFA, thus creating a retrospective way of identifying mistaken Medicare payments.

However, this pay-and-chase approach is inefficient and burdensome on both providers and insurers. We believe a better approach is that Medicare contractors need the ability to identify on a prepayment basis situations where private insurance companies should pay primary to Medicare.

The Department should also seek legislation to establish a MSP voluntary disclosure and recovery program that would authorize administrative sanctions of up to treble damages plus interest for mistaken MSP payments. The Department should seek legislation to require Medicare contractors to match their private side health insurance data with health care files.

Recent work by the OIG indicates $120 million or 20 percent of the total in mistaken primary payments are made annually when the actual private insurer was a Medicare contractor.

We believe we need to restore operations of the MSP units to a level of at least equivalent to the 1989. Direct Medicare contractors need to give priority consideration to developing primary payer sources on spouses of Medicare beneficiaries. This would result in additional annual savings of more than $500 million per year or over 90 percent of the total inappropriate payments

Finally, revise all Medicare claim forms to require an answer of yes or no to the question, do you have health insurance as a result of your spouse's current employment. HCFA is now taking this action to implement this change.

This concludes my testimony, Mr. Chairman, and I would be happy to answer your questions when the appropriate time occurs.

[The prepared statement and draft report follow:]

STATEMENT BY MICHAEL MANGANO, DEPUTY INSPECTOR GENERAL EVALUATION AND INSPECTIONS, OFFICE OF INSPECTOR GENERAL DEPARTMENT OF HEALTH AND HUMAN RESOURCES

GOOD MORNING, MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE. I AM MICHAEL MANGANO, DEPUTY INSPECTOR GENERAL FOR EVALUATION AND INSPECTIONS. I AM ACCOMPANIED THIS MORNING BY BOB SIMON, ASSISTANT INSPECTOR GENERAL FOR CRIMINAL INVESTIGATIONS. WE ARE HERE, AT YOUR REQUEST, TO DISCUSS WITH YOU THE MEDICARE AS SECONDARY PAYER (MSP) PROVISIONS. I WOULD LIKE TO BEGIN BY BRIEFLY DESCRIBING: (1) THE HISTORY OF THE MSP PROGRAM; (2) RECENT WORK THAT HAS BEEN CONDUCTED BY THE OFFICE OF INSPECTOR GENERAL (OIG); (3) AUDIT, EVALUATION, AND INVESTIGATIVE ACTIVITIES THAT HAVE RESULTED FROM NONCOMPLIANCE WITH THE MSP PROVISIONS; AND (4) ADDITIONAL MEASURES WHICH CAN BE TAKEN TO ENSURE THAT THE MSP PROGRAM FUNCTIONS AS INTENDED BY THE CONGRESS.

BACKGROUND

MEDICARE TITLE XVII OF THE SOCIAL SECURITY ACT WAS ESTABLISHED IN 1965 TO PAY FOR HEALTH CARE SERVICES FOR ELIGIBLE BENEFICIARIES AGE 65 AND OLDER. FOR THE FIRST 15 YEARS, MEDICARE WAS THE PRIMARY OR FIRST PAYER FOR ALL HEALTH CLAIMS EXCEPT WHEN THE CLAIMANT WAS COVERED BY WORKERS' COMPENSATION, BLACK LUNG OR VETERANS BENEFITS. BETWEEN 1980 AND 1986, CONGRESS PASSED A SERIES OF STATUTORY PROVISIONS WHICH ESTABLISHED MEDICARE AS THE SECONDARY PAYER TO OTHER INSURERS IN CERTAIN SITUATIONS. APPENDIX A CONTAINS A SUMMARY OF THESE AUTHORITIES AND THE ACTIONS TAKEN TO IMPLEMENT THEM. IN GENERAL, THESE AUTHORITIES, MAKE MEDICARE SECONDARY PAYER TO:

- COVERAGE UNDER AN AUTOMOBILE, NO-FAULT OR LIABILITY INSURANCE PLAN (OMNIBUS RECONCILIATION ACT OF 1980);
- EMPLOYER GROUP HEALTH PLAN (EGHP) COVERAGE OF BENEFICIARIES WHO HAVE KIDNEY FAILURE (END STAGE RENAL DISEASE) DURING THEIR FIRST EIGHTEEN MONTHS OF MEDICARE ENTITLEMENT (OMNIBUS BUDGET RECONCILIATION ACTS OF 1981 AND 1989);
- COVERAGE UNDER AN EGHP (PROVIDED BY AN EMPLOYER OF 20 OR MORE PERSONS) OF WORKING BENEFICIARIES AGE 65 OR OLDER OR THEIR SPOUSES (TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 AS AMENDED BY THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985); AND
- COVERAGE UNDER AN EGHP PROVIDED BY AN EMPLOYER OF 100 OR MORE PERSONS FOR BENEFICIARIES WHO ARE DISABLED (OMNIBUS BUDGET RECONCILIATION ACT OF 1986).

UNDER CURRENT PROCEDURES ADMINISTERED BY THE HEALTH CARE FINANCING ADMINISTRATION (HCFA), HEALTH CARE PROVIDERS ARE REQUIRED TO ASK MEDICARE BENEFICIARIES A SERIES OF QUESTIONS CONCERNING THEIR HEALTH INSURANCE COVERAGE WHEN THE BENEFICIARY IS ADMITTED TO THE HOSPITAL OR WHEN ANY OTHER NON-HOSPITAL SERVICE IS RENDERED. PROVIDERS ARE THEN REQUIRED TO BILL OTHER INSURERS FIRST WHEN BENEFICIARIES FALL WITHIN ONE OF THE MSP CATEGORIES DESCRIBED EARLIER.

MEDICARE CONTRACTORS UNDER CONTRACT WITH HCFA ARE REQUIRED TO SCREEN ALL CLAIMS FOR COVERAGE BY ANOTHER INSURER. THIS IS ACCOMPLISHED BY SEARCHING HISTORY FILES, QUERYING REGIONAL MSP DATA BASES, AND CONTACTING BENEFICIARIES DIRECTLY TO DEVELOP INFORMATION SUCH AS ACCIDENT LIABILITY AND OTHER INSURANCE INFORMATION.

NUMEROUS STUDIES CONDUCTED BY OIG, THE GENERAL ACCOUNTING OFFICE (GAO) AND HCFA HAVE SHOWN THAT DESPITE LEGISLATION MAKING MEDICARE THE SECONDARY PAYER IN CERTAIN SITUATIONS, MEDICARE CONTINUES TO MAKE MISTAKEN PAYMENTS AS PRIMARY PAYER IN A SUBSTANTIAL NUMBER OF CASES. WE HAVE CONDUCTED 27 SEPARATE EVALUATIONS AND AUDITS CONCERNING MSP SINCE MARCH 1984. A LIST OF THESE REPORTS IS CONTAINED IN APPENDIX B AND WE WOULD BE HAPPY TO PROVIDE COPIES OF THESE REPORTS IF YOU DESIRE. THE HCFA HAS TAKEN A NUMBER OF ACTIONS TO IMPROVE METHODS FOR IDENTIFYING CASES WHERE A PRIMARY PAYMENT SOURCE EXISTS. WE HAVE INCLUDED SUMMARIES OF HCFA'S MAJOR INITIATIVES IN APPENDIX C. DESPITE THESE EFFORTS, PROBLEMS STILL EXIST. WE ESTIMATE THAT MORE THAN $600 MILLION WAS LOST TO MEDICARE IN MISTAKEN PAYMENTS IN 1988 AND RECENT INFORMATION SUGGESTS THAT CURRENT PROGRAM LOSSES EXCEED $1 BILLION PER YEAR.

RECENT MSP WORK CONDUCTED BY OIG

I WOULD LIKE TO BRIEFLY DESCRIBE SOME OF OUR RECENT WORK IN THIS AREA:

- WE HAVE RECENTLY COMPLETED A DRAFT REPORT EVALUATING THE PROCEDURES USED BY MEDICARE CARRIERS TO IDENTIFY PRIMARY PAYMENT SOURCES. IF THERE IS NO OBJECTION WE WOULD LIKE TO SUBMIT FOR THE RECORD OUR DRAFT REPORT ENTITLED, *MEDICARE PREPAYMENT REVIEW: MSP PROCEDURES AT CARRIERS*. OUR STUDY FOUND THAT THE MEDICARE CARRIER'S BUDGETS FOR MSP ACTIVITIES WERE REDUCED BY 44 PERCENT FROM FY 1989 TO FY 1990. THIS BUDGET REDUCTION FORCED CARRIERS TO MAKE SIGNIFICANT STAFF REDUCTIONS.

  IN OUR STUDY, THE SEVEN CARRIERS WE VISITED REPORTED THAT THEY REDUCED THEIR STAFF DEVOTED TO MSP OPERATIONS FROM 127 FULL-TIME EMPLOYEES IN 1989 TO 48 IN 1990. AS A RESULT, REPRESENTATIVES FROM FIVE OF THE SEVEN CARRIERS REPORTED THAT THEY WERE NOT CONDUCTING ANY MSP RECOVERY ACTIVITIES AT THE TIME OF OUR REVIEW. THE REPRESENTATIVES FROM OTHER CARRIERS REPORTED THAT THEY WERE RECOVERING SOME OVERPAYMENTS BUT ONLY ON A SELECTIVE BASIS.

  OUR REPORT RECOMMENDS THAT HCFA RESTORE THE OPERATIONS OF THE CARRIER MSP UNITS TO A LEVEL AT LEAST EQUIVALENT TO FY 1989 SO THAT CARRIERS ARE ABLE TO CONDUCT ALL NECESSARY MSP ACTIVITIES. WE BELIEVE THAT THIS ACTION WOULD RESULT IN SAVINGS TO THE MEDICARE PROGRAM OF BETWEEN $199 TO $361 MILLION PER YEAR.

- IN JUNE 1990, WE ISSUED A MANAGEMENT ADVISORY REPORT ENTITLED *MEDICARE SECONDARY PAYER: UNRECOVERED FUNDS*. IN THIS STUDY, WE ANALYZED THE RESPONSES RECEIVED FROM A NATIONAL RANDOM SAMPLE OF OVER 3,000 MEDICARE BENEFICIARIES CONCERNING THEIR HEALTH INSURANCE COVERAGE AND AUTOMOBILE AND OTHER ACCIDENT EXPERIENCES. WE FOUND THAT, WHILE PROGRESS HAS BEEN MADE IN IDENTIFYING MSP SITUATIONS, MORE THAN $600 MILLION IN MISTAKEN MEDICARE PAYMENTS WERE MADE IN 1988.

- IN MARCH 1990, THE OIG ISSUED A FINAL MANAGEMENT ADVISORY REPORT ENTITLED *MORE COMPLETE EMPLOYER GROUP HEALTH PLAN INFORMATION IS NEEDED TO ADMINISTER THE MEDICARE SECONDARY PAYER PROGRAM*. THIS REPORT IDENTIFIED THAT HCFA'S INABILITY TO IDENTIFY MSP SOURCES BEFORE MAKING PAYMENTS CONSTITUTE A MATERIAL INTERNAL CONTROL WEAKNESS. AS SUCH, IT WAS INCLUDED IN THE SECRETARY'S 1989 AND 1990 FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT REPORT TO THE PRESIDENT AND THE CONGRESS.

- IN A FEBRUARY 1990 MANAGEMENT ADVISORY REPORT ENTITLED *MEDICARE AS SECONDARY PAYER-A RESTITUTION PROPOSAL*, THE OIG RECOMMENDED THAT THE DEPARTMENT PROPOSE LEGISLATION TO ESTABLISH A MSP VOLUNTARY DISCLOSURE AND RECOVERY PROGRAM. THE PROGRAM WOULD PERMIT INSURERS, EMPLOYERS (ESPECIALLY SELF-INSURED AND SELF-ADMINISTERED EMPLOYERS) OR THIRD-PARTY ADMINISTRATORS, ACTING WITHIN 1 YEAR, TO IDENTIFY INSTANCES OF MISTAKEN MSP PAYMENTS AND MAKE RESTITUTION OF THE APPROPRIATE AMOUNTS (WITH INTEREST AND COSTS), WITHOUT THREAT OF FUTURE GOVERNMENT ACTION WITH RESPECT TO THOSE CLAIMS.

- IN 1988, THE OIG PUBLISHED A SERIES OF REPORTS COVERING END STAGE RENAL DISEASE, AUTOMOBILE ACCIDENTS AND RELATED CLAIMS, AND MEDICARE BENEFICIARIES COVERED BY EMPLOYER GROUP HEALTH PLANS WHICH WERE NATIONWIDE IN SCOPE, AND WHICH DOCUMENTED A TOTAL OF ABOUT $263 MILLION IN PROJECTED LOSSES TO MEDICARE.

- IN ANOTHER 1988 REPORT, *NATIONWIDE REVIEW OF MEDICARE AS SECONDARY PAYER FOR THE PERIOD SEPTEMBER 1, 1983 THROUGH NOVEMBER 30, 1985*, THE OIG IDENTIFIED, THROUGH A SEPARATE SAMPLE, ANOTHER $20.8 MILLION IN OVERPAYMENTS BECAUSE MEDICARE PAID WHEN OTHER INSURANCE PLANS SHOULD HAVE BEEN PRIMARY PAYERS.

ONGOING ACTIVITIES AND INVESTIGATIVE CASES

THE OIG IS ALSO INVESTIGATING *QUI TAM* LAW SUITS WHICH INVOLVE ALLEGATIONS OF FALSE CLAIM ACT VIOLATIONS INVOLVING THE DEPARTMENTAL PROGRAMS. IN THESE CASES, ANY PERSON HAVING KNOWLEDGE OF A FALSE CLAIM AGAINST THE GOVERNMENT MAY BRING AN ACTION IN A FEDERAL DISTRICT COURT FOR THEMSELVES ON BEHALF OF THE GOVERNMENT, PURSUANT TO THE *QUI TAM* PROVISIONS OF THE FALSE CLAIMS ACT. EACH TIME A *QUI TAM* CASE IS FILED AND SENT UNDER SEAL TO THE DEPARTMENT OF JUSTICE (DOJ) TO

CONSIDER WHETHER THE GOVERNMENT SHOULD TAKE OVER PROSECUTION OF THE CASE ON ITS OWN BEHALF, DOJ CONTACTS THE OIG TO CONDUCT AN INVESTIGATION AND MAKE A REPORT AND RECOMMENDATION TO DOJ. THE OIG HAS THUS FAR CONDUCTED FIVE MSP INVESTIGATIONS RELATED TO SUITS FILED UNDER THE *QUI TAM* PROVISION OF THE FALSE CLAIMS ACT. IN EACH CASE WE RECOMMENDED THAT THE GOVERNMENT NOT JOIN THE *QUI TAM* SUIT BUT INSTEAD RESERVE THE RIGHT TO INTERVENE AT A LATER TIME IF APPROPRIATE.

IN MARCH 1988, WE INITIATED A CRIMINAL INVESTIGATION INVOLVING A MAJOR HEALTH INSURANCE COMPANY. THIS INVESTIGATION WAS INITIATED BASED ON INFORMATION CONTAINED IN A LAW SUIT FILED BY A PRIVATE LAW FIRM UNDER THE *QUI TAM* PROVISIONS ALLEGING THAT THE INSURER HAD DEFRAUDED THE MEDICARE PROGRAM BY INTENTIONALLY PAYING BENEFITS AS SECONDARY TO MEDICARE WHEN THE INSURER KNEW THAT THEY HAD PRIMARY LIABILITY. THE DEPARTMENT OF JUSTICE (DOJ) HAS DECLINED TO PROSECUTE THIS CASE, HOWEVER, THE GOVERNMENT IS PURSUING CIVIL RECOVERY AGAINST THIS INSURER.

WE ARE CURRENTLY AUDITING FIVE MEDICARE CONTRACTORS TO DETERMINE IF THEY ARE COMPLYING WITH MSP PROVISIONS AND PROCEDURES AND TO DETERMINE THE AMOUNT OF IMPROPER MEDICARE PRIMARY PAYMENTS. THESE REVIEWS ARE BEING CONDUCTED AT AETNA INSURANCE COMPANY, TRAVELERS INSURANCE COMPANY, EMPIRE BLUE CROSS-BLUE SHIELD, BLUE CROSS AND BLUE SHIELD OF FLORIDA, AND BLUE CROSS BLUE SHIELD OF MICHIGAN. THE OIG HAS ISSUED SUBPOENAS TO EACH COMPANY, AND, IN THE CASE OF MICHIGAN AND TRAVELERS, IS WORKING WITH THE DEPARTMENT OF JUSTICE WHICH HAS FILED SUIT FOR COLLECTION OF MSP PAYMENTS. AS PART OF OUR AUDIT, WE ARE PERFORMING A SERIES OF COMPUTER MATCHES AIMED AT IDENTIFYING MISTAKEN MEDICARE PAYMENTS. DIFFERENCES IN DATA LAYOUT FORMATS AND A SIGNIFICANT AMOUNT OF MISSING INFORMATION HAS DELAYED COMPLETION OF OUR AUDITS. WE ARE AGGRESSIVELY PURSUING THE RESOLUTION OF THESE PROBLEMS.

WHAT ACTIONS STILL NEED TO BE TAKEN?
THE FOLLOWING OIG RECOMMENDATIONS HAVE BEEN MADE TO HCFA AND WOULD HELP CORRECT MSP PROBLEMS:

LEGISLATIVE ACTIONS

- THE OMNIBUS BUDGET RECONCILIATION ACT OF 1989 PROVIDES FOR AN EXCHANGE OF INFORMATION BETWEEN THE INTERNAL REVENUE SERVICE, SOCIAL SECURITY ADMINISTRATION, AND HCFA, THUS CREATING A RETROSPECTIVE WAY OF IDENTIFYING MISTAKEN MEDICARE PAYMENTS. HOWEVER, THIS "PAY AND CHASE" APPROACH IS INEFFICIENT AND BURDENSOME ON BOTH PROVIDERS AND INSURERS.

  WE CONTINUE TO BELIEVE THAT MEDICARE CONTRACTORS NEED THE ABILITY TO IDENTIFY, ON A PREPAYMENT BASIS, SITUATIONS WHERE PRIVATE INSURANCE COMPANIES SHOULD PAY PRIMARY TO MEDICARE. WE, THEREFORE, BELIEVE THAT ADDITIONAL LEGISLATIVE ACTION IS NECESSARY TO FULLY RESOLVE THIS PROBLEM AND CORRECT THE MATERIAL WEAKNESS IDENTIFIED IN

THE SECRETARY'S FMFIA REPORT.

THE PRESIDENT'S BUDGET SUBMISSION FOR FY 1992 CONTAINS A PROVISION TO ESTABLISH A CLEARINGHOUSE FOR THIRD PARTY LIABILITY DATA. THIS CLEARINGHOUSE IS INTENDED TO ACQUIRE DATA FROM EMPLOYERS ON EMPLOYMENT BASED HEALTH INSURANCE FOR ALL FEDERAL AGENCIES AND FOR STATE MEDICAID AGENCIES. THE CLEARINGHOUSE WOULD REPLACE THE EXISTING EXCHANGE OF INFORMATION PROCESS BETWEEN THE INTERNAL REVENUE SERVICE, THE SOCIAL SECURITY ADMINISTRATION, AND HCFA. BY MODIFYING W-2 FORMS TO COLLECT EGHP INFORMATION THE CLEARINGHOUSE WOULD ENABLE THE DEPARTMENT TO COLLECT MORE ACCURATE AND TIMELY INFORMATION TO IDENTIFY PRIMARY PAYERS. THIS IS CONSISTENT WITH AN OIG RECOMMENDATION TO USE THE W-2 FORM TO COLLECT THIS VALUABLE INFORMATION.

- THE DEPARTMENT SHOULD SEEK LEGISLATION TO ESTABLISH A MSP VOLUNTARY DISCLOSURE AND RECOVERY PROGRAM. THAT WOULD AUTHORIZE ADMINISTRATIVE SANCTIONS OF UP TO TREBLE DAMAGES PLUS INTEREST FOR MISTAKEN MSP PAYMENTS. THE PROGRAM WOULD PERMIT INSURERS, EMPLOYERS, OR THIRD-PARTY ADMINISTRATORS, TO IDENTIFY INSTANCES OF MISTAKEN MSP PAYMENTS AND MAKE RESTITUTION OF THE AMOUNTS WITHOUT THREAT OF FUTURE GOVERNMENT ACTION WITH RESPECT TO THOSE CLAIMS. ANY INSURER NOT PARTICIPATING IN THIS PROGRAM WOULD BE SUBJECT TO DAMAGES (WE SUGGEST TREBLE), PLUS COSTS, WITH RESPECT TO ALL MISTAKEN MSP CLAIMS LATER IDENTIFIED BY THE GOVERNMENT. AS PART OF THIS PROPOSAL, WE ALSO RECOMMENDED EXTENDING THE STATUTE OF LIMITATIONS FOR MISTAKEN MSP PAYMENTS.

- THE DEPARTMENT SHOULD SEEK LEGISLATION TO REQUIRE MEDICARE CONTRACTORS TO MATCH THEIR PRIVATE SIDE HEALTH INSURANCE DATA WITH MEDICARE FILES. THE CONGRESS PROHIBITED HCFA FROM IMPLEMENTING THIS MATCHING ACTIVITY IN OBRA 89. WE BELIEVE THAT CONTRACTORS HAVE A FIDUCIARY RESPONSIBILITY TO THE FEDERAL GOVERNMENT TO ASSURE THAT ONLY APPROPRIATE MEDICARE PAYMENTS ARE MADE. IF WE ARE CORRECT, IT FOLLOWS THAT, CONTRACTORS, BY FAILING TO MATCH THEIR PRIVATE INSURANCE FILES WITH MEDICARE FILES ARE BREACHING THIS RESPONSIBILITY AND ARE CREATING A CONFLICT OF INTEREST. RECENT WORK BY OIG INDICATES THAT $120 MILLION (OR 20 PERCENT OF THE TOTAL) IN MISTAKEN PRIMARY PAYMENTS ARE MADE ANNUALLY WHEN THE ACTUAL PRIMARY INSURER WAS THE MEDICARE CONTRACTOR. REQUIRING THESE MATCHING ACTIVITIES WOULD HELP PREVENT THESE MISTAKEN PAYMENTS.

ADMINISTRATIVE ACTIONS

WE HAVE RECOMMENDED THAT HCFA:

- RESTORE OPERATIONS OF THE MSP UNITS TO A LEVEL AT LEAST EQUIVALENT TO FY 1989.

- DIRECT MEDICARE CONTRACTORS TO GIVE PRIORITY

CONSIDERATION TO DEVELOPING PRIMARY PAYER SOURCES ON SPOUSES OF MEDICARE BENEFICIARIES. IDENTIFYING AND RECOVERING INAPPROPRIATE PAYMENTS RELATING TO SPOUSES WOULD RESULT IN ADDITIONAL ANNUAL SAVINGS OF MORE THAN $500 MILLION PER YEAR (OVER 90 PERCENT OF THE TOTAL INAPPROPRIATE PAYMENTS).

- REVISE ALL MEDICARE CLAIM FORMS TO REQUIRE AN ANSWER OF "YES" OR "NO" TO THE QUESTION, "DO YOU HAVE HEALTH INSURANCE AS A RESULT OF YOUR, OR YOUR SPOUSE'S CURRENT EMPLOYMENT?" HCFA IS NOW TAKING ACTION TO IMPLEMENT THIS CHANGE. WE WOULD FUTHER SUGGEST THAT HCFA THEN AMEND INSTRUCTIONS TO MEDICARE CONTRACTORS TO SPECIFY THAT IF THE SECTION ON THE CLAIM FORM PERTAINING TO EMPLOYEE INSURANCE IS BLANK, THE CLAIM SHOULD BE SUSPENDED AND RETURNED EXPLAINING THAT THE OTHER HEALTH INSURANCE COVERAGE QUESTION MUST BE ANSWERED.

CONCLUSION

THE MSP PROVISIONS WERE ENACTED AS A RESULT OF SIGNIFICANT INCREASES IN MEDICARE COSTS. SHIFTING THE RESPONSIBILITY FOR HOSPITAL AND MEDICAL CLAIMS TO THOSE PRIVATE PLANS COVERING THE "WORKING AGED" OR INJURIES ARISING FROM ACCIDENTS WAS SEEN AS EQUITABLE AND NECESSARY IN LIGHT OF THE NEED TO CONTROL SPIRALING MEDICARE EXPENDITURES.

UNFORTUNATELY, THE IMPLEMENTATION OF THE MSP PROVISIONS HAS NOT MET THE GOALS INTENDED BY THE CONGRESS. STUDIES BY THE OIG, HCFA AND GAO HAVE SHOWN THAT HUNDREDS OF MILLIONS OF DOLLARS ARE STILL LOST EACH YEAR BECAUSE MSP SITUATIONS CANNOT BE ADEQUATELY IDENTIFIED AND PURSUED. ACTIONS BY HCFA, WHILE ACHIEVING SAVINGS OF $2.2 BILLION IN FY 1989, HAVE NOT ELIMINATED THE PROBLEMS.

IN THIS TESTIMONY WE HAVE OUTLINED NUMEROUS ACTIONS WHICH COULD RESULT IN SUBSTANTIAL RECOVERIES AND INSURE THAT THE MSP PROVISIONS ARE ACHIEVING THE GOALS INTENDED BY CONGRESS.

THIS CONCLUDES MY TESTIMONY. WE ARE AVAILABLE TO ANSWER YOUR QUESTIONS.

APPENDIX A

MEDICARE SECONDARY PAYER LEGISLATION

TITLE OF LAW	PUBLIC LAW	ENACTMENT DATE	EFFECTIVE DATE	DESCRIPTION
Omnibus Reconciliation Act of 1980 (ORA)	95-499	12-05-80	06-06-83	ORA made Medicare the secondary payer for automobile accident related claims.
Omnibus Budget Reconciliation Act of 1981 (OBRA 81)	97-035	08-13-81	01-01-83	OBRA-81 made Medicare benefits secondary to EGHPs for beneficiaries with end stage renal disease.
Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)	97-248	09-03-82	01-01-83	TEFRA made Medicare benefits secondary if the employee or spouse is age 65 through 69 covered by an EGHP and the employer has at least 20 employees.
Deficit Reduction Act of 1984 (DEFRA)	98-369	07-18-84	01-01-85	DEFRA broadened the definition of working spouse by including spouses age 65-69 of employed individuals under age 65, thereby removing the lower age limit.
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)	98-272	04-06-86	05-01-86	COBRA further broadened the definition of working aged by removing the limitation of age 70 and older.
Omnibus Budget Reconciliation Act of 1986 (OBRA 86)	99-509	10-21-86	01-01-87	OBRA-86 made Medicare items and services secondary for payment if the disabled beneficiary or spouse is working and covered under an EGHP.
Omnibus Budget Reconciliation Act of 1989 (OBRA 89)	101-239	12-19-89	12-19-89	OBRA-89 provided a two year period for matching IRS tax records to records of the Social Security Administration and the Health Care Financing Administration to identify working beneficiaries and their spouses.

APPENDIX B

PREVIOUSLY PUBLISHED REPORTS

1. Priority Audit Memorandum - Survey of the Tax Equity and Fiscal Responsibility Act of 1982 - March 7, 1984, Control Number: ACN-03-42009

2. Medicare Secondary Payer Provision End-Stage Renal Disease - Program Inspection Report - August 24, 1984, Control Number: 1-07-4001-14

3. Medicare Secondary Payer Provision End-Stage Renal Disease - South Dakota - November 20, 1984, Control Number: 1-08-4009-14

4. Medicare Secondary Payer Provision End-Stage Renal Disease - Colorado - December 4, 1984, Control Number: 1-08-4001-14

5. Medicare Secondary Payer Provision End-Stage Renal Disease - Program Inspection Report - April 3, 1985, Control Number: 1-07/08-4002-14

6. Medicare Secondary Payer Provision Automobile Medical and No-Fault Insurance - North Dakota - May 1, 1985, Inspection Control Number: 03-08-5001-14

7. Program Inspection of Medicare as a Secondary Payment Source for Beneficiaries with End-Stage Renal Disease in the State of Oregon - May 10, 1985, Inspection Control Number: 3-10-4008-14

8. Medicare as Secondary Payer for Medical Services Related to Automobile Accidents in Massachusetts - June 1985, Control Number: 1-01-4105-31

9. Medicare as Secondary Payer for Medical Services Related to Automobile Accidents in Massachusetts - Boston - June 1985, Control Number: 1-01-4105-32

10. Medicare Secondary Payer Provision Automobile Liability and Medical Insurance - State of Missouri - Program Inspection Report - December 1985, Control Number: 3-07-5001-32

11. Medicare Secondary Payer Provision Automobile Medical and No-Fault Insurance - State of Colorado - Program Inspection Report - December 1985, Control Number: 3-08-5002-14

12. Medicare Secondary Payer Provision Credit Balances in Medicare Beneficiary Hospital Accounts, Control Number: OPI-85-070-040

13. Medicare Secondary Payer Provision Working Aged in Missouri - July 1986, Control Number: P-07-86-00079

14. Medicare Secondary Payer Provision Working Aged in Colorado - July 1986, Control Number: P-07-86-00071

15. OIG Audit Report - Medicare Overpayments for Services Provided to Beneficiaries with End-Stage Renal Disease - April 28, 1987, Control Number: A-10-86-62003

16. OIG Audit Report - Retirees of Exempt State and Local Government Could Cost Medicare $12.8 Billion over the next 5 Years - September 10, 1987, Control Number: CIN A-09-86-62050

17. Amending the Medicare Secondary Payer Provision for ESRD Beneficiaries Could Save the Medicare Program $3 Billion Over the Next 5 Years - December 1, 1987, Control Number: CIN A-10-86-62016

18. Medicare as a Secondary Payment Source - End-State Renal Disease - January 1988, Control Number: OAI-07-86-00092

19. Medicare as a Secondary Payment Source - January 1988, Control Number: OAI-07-86-00017

20. Medicare as a Secondary Payment Source - Medicare Beneficiaries Covered By Employer Group Health Plans - February 1988, Control Number: OAI-07-86-00091

21. Nationwide Review of Medicare as Secondary Payer for the Period September 1, 1983 through November 30, 1985, Control Number: CIN A-10-86-62005

22. Management Advisory Report: Medicare as Secondary Payer -Restitution Proposal, Control Number: AO-12-89-00002

23. Management Advisory Report: More Complete Employer Group Health Plan Information is Needed to Administer the Medicare Secondary Payer Program, Control Number: A-09-89-00100

24. Draft Management Advisory Report: MSP Survey - Contractors Questionnaire, Control Number: A-09-89-00151

25. Exposure Draft OIG Management Advisory Report: Overview of Medicare Secondary Payer Systems: Strategies for Improvement, Control Number: OAI-07-90-00740

26. Management Advisory Report: Medicare Secondary Payer: Unrecovered Funds, Control Number: OEI-07-90-00764

27. Draft Report: Medicare Prepayment Review: MSP Procedures at Carriers, Control Number: OEI-07-89-01683 December 1990

APPENDIX C

MEDICARE SECONDARY PAYER INITIATIVES CONDUCTED BY THE HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Contractor Data Match

In 1984, HCFA piloted two types of computer matches (matching enrollment records and matching claims records) plus a general mailing approach to determine if any of these were effective methods of identifying MSP situations. Fifteen contractor sites were included in these tests. Results of the pilots indicated that matching enrollment records was the more effective matching technique, producing a rate of return of between $5 and $8 recovered for each dollar spent as compared to a recovery rate of between $4 and $6 using the claims matching methodology. However, inasmuch as systems differences among contractors limited its applicability at the time, it was not implemented as a national requirement.

Beneficiary Questionnaires

In 1985, HCFA required Medicare contractors to send 65 to 69 year old beneficiaries a questionnaire requesting employment status, private employer health insurance information, spouse's employment status, age, and employer health insurance information. The mailing was determined to be a cost effective method of identifying new MSP sites. Test results indicated a 5 percent new identification rate on these mailings and a rate of return of between $32 and $48 saved for every dollar spent.

Data Matches with Workers' Compensation Agencies

In 1986, HCFA advised Medicare contractors to obtain information from State Workers' Compensation agencies and to match that information against beneficiary records to detect those instances where workers' compensation was involved in the need for medical care. If a match occurs, the contractor determines whether Workers' Compensation should have been the primary payer and seeks to recover erroneously paid benefits. At contractors where such information exchanges have been negotiated (approximately 15) savings have increased by approximately 25 percent.

HCFA/SSA MSP Pilot Project

Also in 1986, HCFA tested the feasibility of identifying, through existing information channels at SSA, employment related health insurance that is primary to Medicare. The information was collected at the time of application for retirement benefits and furnished to contractors as potential MSP leads. The pilot was conducted in six States and furnished strong indicators that this process is a successful method of identifying beneficiaries who fall under the various MSP provisions. SSA has requested further study of this pilot while they develop an automated system for collecting and transmitting retirement data.

Regional Data Exchange System (RDES)

In 1987, HCFA implemented a regional MSP exchange of information system. Under this procedure, MSP information is gathered from all contractors within the region by a Regional Data Exchange manager who compiles all information and distributes it to the contractors in the Region. This information is also available, upon request, to contractors outside the Region. This MSP data base identifies beneficiaries that have a confirmed primary insurer other than Medicare. Sharing information reduces development of a claims by multiple contractors and ensures prepayment denial of MSP claims.

First Claim Development

In 1987, HCFA established a procedure which requires contractors to send a letter to each beneficiary age 65 or 66 when the contractor receives a claim from that beneficiary and no previous activity was noted and information on the billing form is incomplete. The letter explains the MSP provisions and asks that the beneficiary provide information on any coverage they maintain which might be primary to Medicare. This is the best method in use today to initially identify persons who have other insurance coverage and to keep existing data bases up to date.

Outreach Educational Campaign

In 1988, HCFA developed an educational package describing the MSP program and mailed it to over 500,000 physicians across the country. HCFA also developed a series of public service announcements for radio and television designed to make Medicare beneficiaries aware of Medicare Secondary Payer. These are currently being broadcast in the 30 largest television markets. Based on a follow-up survey we know that physicians and their staffs found the material informative and useful, and that the PSAs were being aired in many time slots on a continuing basis.

DRAFT

MEDICARE PREPAYMENT REVIEW
MSP PROCEDURES AT CARRIERS

RICHARD P. KUSSEROW
INSPECTOR GENERAL

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OEI-07-89-01683 DECEMBER 1990

EXECUTIVE SUMMARY

PURPOSE

To evaluate the procedures used by Medicare carriers to identify primary payment sources other than Medicare.

BACKGROUND

This inspection is part of an initiative to examine the effectiveness of Medicare carriers' prepayment utilization review processes.

Until 1980, Medicare was the primary payer of health care costs for Medicare beneficiaries except when the beneficiary is covered by a worker's compensation program or the Veterans Administration. Congress became concerned about significant increases in the cost of the Medicare program. As a result, between 1980 and 1986 Congress passed a series of statutory provisions requiring certain private insurers to pay medical claims before Medicare (See Appendix A).

These provisions created new functions for Medicare contractors. They are responsible for screening, identifying, and verifying claims for other insurance involvement. In addition, contractors are required to make recoveries when Medicare has paid improperly.

In line with Health Care Financing Administration (HCFA) efforts to reduce program administrative costs, the budget for MSP functions at Medicare Carriers was reduced by approximately 44% from FY 1989 to FY 1990.

METHODOLOGY

We selected a sample of seven Medicare carriers for review based on high and low volumes of claims processed. An inspection team conducted field visits to each carrier. We interviewed the manager and/or supervisor of the MSP units of each carrier in our sample. Additional documentation collected during this review was used to support and verify information gathered during these interviews. This documentation included published materials, claims forms, monthly in-house MSP savings reports, and HCFA-1564 savings reports.

FINDINGS

THE FY 1990 MSP BUDGET REDUCTION

Carriers' budgets for MSP activities were reduced by 44% for FY 1990.

Carriers made significant staff reductions to cope with the MSP budget reduction.

Most carriers do not recover overpayments following identification of MSP situations.

Representatives from five of seven carriers in this review told the review team that they are conducting no MSP recovery activities. Representatives from the two remaining sample carriers indicated that they are recovering overpayments on a selective basis. These carriers recover those cases that have greatest potential for savings and only do so within their current operating budget.

The HCFA's "required task" list does not include the recovery of MSP overpayments.

MSP SAVINGS ISSUES

Inconsistencies exist in methods used to identify and calculate savings.

RECOMMENDATIONS

The HCFA should ensure that carriers restore operations of the MSP units to a level at least equivalent to FY 1989.

The HCFA should conduct demonstration programs evaluating incentives to enhance the identification and recovery of inappropriate MSP payments.

We present several options for how these demonstration programs could be structured. By implementing one of these options we estimate that additional savings could range from $199 million to $361 million.

The HCFA should modify the CPEP standards to evaluate carriers on their MSP identification and recovery efforts.

The HCFA should provide clear and uniform procedures for counting MSP savings.

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INTRODUCTION

PURPOSE

To evaluate the procedures used by Medicare carriers to identify primary payment sources other than Medicare.

BACKGROUND

This inspection is part of an initiative to examine the effectiveness of Medicare carriers' prepayment utilization review processes.

History of Medicare Secondary Payer (MSP) Provisions

Medicare helps pay medical costs for approximately 28 million people aged 65 and older and approximately 3 million disabled people. Medicare Part A covers inpatient hospital services, home health services, and other institution-based services. Physician, outpatient hospital, and various other health services are covered by Medicare Part B.

The Health Care Financing Administration (HCFA) is responsible for ensuring compliance with Medicare legislation and regulations. Private insurance companies contract with HCFA to process and pay Medicare claims. These contractors are known as fiscal intermediaries (Part A) and carriers (Part B).

Until 1980, Medicare was the primary payer of health care costs for Medicare beneficiaries except when the beneficiary is covered by a worker's compensation program or the Veterans Administration. Congress became concerned about significant increases in the cost of the Medicare program. As a result, between 1980 and 1986 Congress passed a series of statutory provisions requiring certain private insurers to pay medical claims before Medicare.

These provisions require private insurers to pay medical claims primary to Medicare when the beneficiary has other health insurance coverage by an employer group health plan (EGHP), a disabled beneficiary's EGHP, a spouse's EGHP, or automobile, no-fault, or liability insurance (see Appendix A for details of these provisions). After the private insurance company pays up to its coverage limits, Medicare reimburses remaining covered services subject to coinsurance and deductible limits.

Implementation of MSP Provisions

These provisions created new functions for Medicare contractors. They are responsible for screening, identifying, and verifying claims for other insurance involvement. In addition, contractors are required to make recoveries when Medicare has paid improperly.

The HCFA provides contractors with procedures and instructions to identify primary payment sources. When a Medicare claim is submitted, the contractor searches MSP history files for coverage by another insurer. The most widely used contractor procedures for identifying MSP situations include

- developing leads from HCFA's "Y-trailer" codes;
- screening information included on the claim form;
- querying data in the Regional Data Exchange System (RDES);
- developing the first claim filed by or on behalf of a beneficiary; and
- reviewing all claims containing medical diagnosis codes indicating trauma--to identify injuries related to automobile or work-related accidents.

These procedures helped save approximately $2.2 billion in FY 1989 by identifying primary insurers. However, HCFA actuary estimates, Office of Inspector General (OIG) inspections, and audits by the OIG and the General Accounting Office (see Appendix B for a list of previously published reports) have confirmed that additional savings are possible through improvements to current MSP identification and overpayment recovery systems. The OIG has estimated, based on a random sample of Medicare beneficiaries, that Medicare lost in excess of $600 million in FY 1988 due to unidentified primary payment sources.

The carriers' FY 1990 budgets for MSP activities was significantly reduced from the FY 1989 level. The HCFA actuary estimates that the Medicare program lost approximately $900 million in FY 1990. The current estimate of Medicare program losses due to failure to identify primary payment sources and recover inappropriate Medicare payment has increased to $1.3 billion for FY 1991.

Evaluation of Contractors

The HCFA establishes MSP savings goals for all contractors. The carriers and intermediaries calculate and record all savings resulting from MSP situations. These savings are reported to HCFA on a monthly savings report (HCFA-1564). Contractors are evaluated on achievement of the MSP savings goals as part of their Contractor Performance Evaluation Program (CPEP).

The HCFA establishes four types of MSP savings.

- Cost avoided MSP claims are those the carrier returns without payment because there is strong evidence that another insurer is the primary payer.

- Full recoveries are defined as savings from claims that were paid by a private insurance company, relieving Medicare of all payment liability.

- Partial recoveries are those situations when the primary payer's payment only covers part of the Medicare allowable charge. In this situation Medicare pays the remaining amount up to what Medicare has allowed.

- Pending claims are those where MSP has been verified but all funds have not been recovered.

METHODOLOGY

We selected a sample of seven Medicare carriers for review based on the volume of claims processed. Six of the sample carriers have high volumes of claims processed and one is considered low volume. The sample carriers include: Blue Shield of Massachusetts-Tri-State; Blue Shield of Florida, Inc; Blue Shield of Indiana; Blue Shield of Texas, Inc.; Blue Shield of Colorado; Arkansas Blue Cross & Blue Shield, Inc.; and Blue Shield of Kansas City.

We visited each carrier to obtain information about the effects of the FY 1990 budget reduction. We obtained data about the effects the reduction had on staff size and numbers of claims processed. In order to learn what procedures the carriers have established to handle MSP claims with reduced resources, we conducted interviews with the manager and/or supervisor of the MSP unit at each carrier. A second interview was conducted with the staff member most familiar with the budget process and budget issues.

In addition, we selected a random sample of 30 claims from the MSP savings log or equivalent computer generated report at each carrier. This sample was selected from the claims processed during the fourth quarter of FY 1989. These claims were analyzed and followed through the MSP development process to the HCFA-1564 monthly savings report. The carriers provided documentation to support the MSP savings claimed on this report.

FINDINGS

THE FY 1990 MSP BUDGET REDUCTION

Carriers' budgets for MSP activities were reduced by 44% for FY 1990.

The carriers' FY 1990 budget for MSP activities was significantly reduced from the FY 1989 level. Table 1 presents a summary of contractors' budgets for the last three fiscal years. The entire budget reduction was applied to carriers. In fact, the intermediaries budget actually increased by 5.7%.

The return on investment (ROI) figures calculated by HCFA represent the ratio of program dollars saved as compared to administrative dollars spent. These figures illustrate that MSP activities are cost effective.

Table 1

Contractor Budgets and Return on Investment

for MSP Activities

	FY 1988	ROI*	FY 1989	ROI	FY 1990	ROI**
INTERMEDIARIES	$31,508,823	45:1	$32,800,966	50:1	$34,672,890	52:1
CARRIERS	$34,598,000	13:1	$37,579,565	14:1	$21,271,700	22:1
TOTAL	$66,106,823		$70,380,531		$55,944,590	

* ROI = Return on Investment
** The ROI figures for 1990 represent eight months

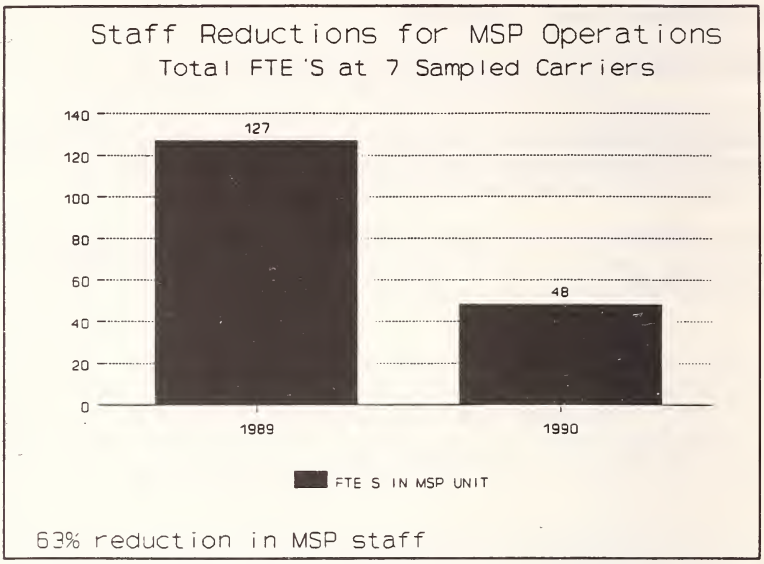
Carriers made significant staff reductions to cope with the MSP budget reduction.

The most visible result of the reduced MSP budget is that it forced carriers to make significant staff reductions. These reductions made it impossible to maintain all MSP activities at the levels of prior years.

The following graph illustrates the staff reductions at the seven sample carriers for FY 1989 to 1990. These carriers reduced their Medicare-funded full time equivalents (FTEs) for MSP functions by 63%. In order to maintain adequate operating levels,

43-492 - 91 - 2

two sampled carriers were receiving financial support from their private business. The data presented in the graph below does not reflect this support.



The budget reduction in FY 1990 will have long term effects on the operation of the carriers' MSP units. The budget proposal for FY 1991 includes a five million dollar increase for carrier MSP activities. Respondents indicated that this increase will not allow the carrier to "catch up" on a year's backlog created from operating without sufficient personnel. Carriers would use additional funds to recruit and train new personnel.

When questioned about the effect of the budget cut, one typical manager said, "It will be several years before we rebound from this budget cut. Recruiting and training someone from off the street takes a long time." Another typical manager commented, "We were forced to lay off efficient employees. The work we do in the MSP unit is complicated and the learning curve for these tasks is very large." We heard these and many similar comments at all sample carriers.

Most carriers do not recover overpayments following identification of MSP situations.

When carriers identify and develop potential MSP situations through the usual sources (i.e. first claim development, RDES, "Y-trailer" codes, etc), they deny MSP

claims and count the MSP savings from this denial on the HCFA-1564 savings report. However due to the budget and staff reductions for FY 1990, the carriers do not conduct further MSP development or initiate recoveries on claims previously paid by Medicare. These unassessed program losses are in addition to the OIG's current estimate of losses due to the MSP provisions. These new losses have been created by the carriers' inability to continue MSP operations at the same levels prior to the budget reduction.

Representatives from five of seven carriers in this review told the review team that they are conducting no MSP recovery activities. Representatives from the two remaining sample carriers indicated that they are recovering overpayments on a selective basis. These carriers recover those cases that have greatest potential for savings and only do so within their current operating budget.

When asked what development and recovery action is taken on claims that may have been inappropriately paid by Medicare, respondents indicated that they were being stored in boxes and file cabinets. The inspection team observed these claims firsthand at all seven sample carriers. Carrier representatives said that these recoveries will be made when, or if, additional funding and development staff become available.

We asked respondents from the carrier's MSP staff if they knew or could estimate the value of the inappropriately paid claims waiting to be recovered. No one could provide an adequate count or estimate of the number and/or value of these claims. However, all indicated that if this substantial amount was recovered, it would accelerate the carriers' progress toward their MSP savings goal.

A recent audit conducted by the OIG Office of Audit Services has also verified this backlog of claims. Additional inspection work could provide an accurate estimate of the lost savings.

The HCFA's "required task" list does not include the recovery of MSP overpayments.

The aggressive collection of debts due the United States Government is required by statute and regulations, these regulations include the Federal Claims Collection Act and 4 CFR 102.1. Despite these requirements, HCFA has not placed emphasis on the recovery of overpayments resulting from previously unidentified primary payment sources.

In November 1989, correspondence from HCFA provided carriers with MSP claims processing and development priorities for coping with the budget reduction. These priorities are divided into two lists (see Appendix C). The first list contains "required tasks" and the second includes those tasks that should be undertaken "to the extent that funds are available." Recovery of MSP overpayments is not included on the "required task" list and is the third of four items on the second list. The

decision on how much time and effort the carriers expend to make recoveries is left to the carrier's discretion.

The carriers are not directly evaluated on the various methods used to identify and recover overpayments. This is evidenced by the absence of a CPEP performance standard to specifically evaluate the carriers' effectiveness in implementing the various procedures for identifying MSP situations or recovering MSP overpayments. Currently, the only criteria used to evaluate the performance and effectiveness of the MSP units are based on achievement of the pre-established MSP goals.

MSP SAVINGS ISSUES

Inconsistencies exist in methods used to identify and calculate savings.

The HCFA calculates MSP savings goals for all contractors at the beginning of each fiscal year. The HCFA has issued instructions and procedures explaining the methods that should be used to calculate MSP savings. However, carriers are not counting and calculating these savings uniformly, and some of the savings being counted are questionable.

- The HCFA procedures do not require carriers to query for deductible status when calculating savings. This allows carriers to count a deductible amount paid by the beneficiary as MSP savings. The deductible amount is not savings because the beneficiary would pay this amount in any situation. Four sample carriers were not completing such queries but were claiming deductible amounts as savings. Three sample carriers were querying for deductible status but were not counting the deductible as savings.

- The HCFA allows carriers to count savings when an outside source pays a claim as the primary payer and the carrier is informed of this payment by an outside source (i.e. insurance company or physician's office). These savings are counted by some carriers even though no claim is submitted to the carrier. In this situation, savings amounts must be estimated by the carrier because they do not pass through the carrier's system. Four of the sample carriers were counting these situations as savings. Three sample carriers were not counting these situations as savings.

RECOMMENDATIONS

The HCFA should ensure that carriers restore operations of the MSP units to a level at least equivalent to FY 1989.

The FY 1990 budget reduction for MSP activities has affected carriers' ability to handle the MSP workload. Carriers face a huge backlog of potential MSP recovery cases with reduced staffing and funding. In order to effectively identify and recover all possible MSP situations, the carriers must use all procedures available to them. Restoring the MSP unit's operational efforts to the levels of the prior year will help carriers utilize current procedures to identify and recover as many MSP savings as possible.

To accomplish this, it might be necessary to restore appropriations to previous levels. An alternative would be to provide the funding out of savings captured by each contractor. The next recommendation provides details of this option.

The HCFA should conduct demonstration programs evaluating incentives to enhance the identification and recovery of inappropriate MSP payments.

Many sources have established that Medicare funds continue to be lost due to unidentified primary payment sources. An incentive program would provide the carriers an opportunity to increase Medicare savings while supplementing their operating budget. This incentive program should not supercede any current MSP requirements and procedures. Carriers would be required to maintain all educational efforts at the current level.

Current MSP procedures are cost effective. This is illustrated by the data presented in Table 1 on page 4 of this report. Medicare is currently saving 13 to 22 dollars for every dollar spent for operations at the carriers' MSP units. As long as these return on investment figures remain positive, an incentive program will be cost effective for the Medicare program.

The following options describe some of the many possibilities for this incentive program. By implementing one of these options, we estimate that additional savings could range from $199 million to $361 million. We suggest that HCFA evaluate these options for demonstration programs and determine appropriate reimbursement percentages for these incentives.

OPTION A: Participating carriers could be allowed to use five percent of all savings they identify during the year to increase their ability to identify MSP situations. These payments would not be included as part of the carriers' contract budgets.

OPTION B: Participating carriers could be allowed to use five percent of all savings identified during the year plus an additional two percent of all savings from recoveries made on claims that were previously paid inappropriately. As in Option A, these payments would be used by the carrier's MSP unit to finance part of their activities. This option would provide additional funding to aggressively collect inappropriate payments.

OPTION C: Participating carriers could be allowed to keep a total of five percent of identified savings. Three percent would be used by the carrier's MSP unit to finance collection efforts. The remaining two percent could be an incentive payment used in any area of the Medicare operation or be retained as profit. This option could provide an even greater incentive to the carriers because they would have more flexibility in utilizing these incentive payments.

OPTION D: Participating carriers could be allowed to keep twenty-five percent of the savings carriers identify and/or collect above their established MSP savings goal. This option provides an incentive for carriers to continue to aggressively pursue all potential MSP cases even after the yearly MSP savings goal is achieved. As in Option C, 60 percent of these payments would be used to finance collection efforts, the remaining 40% would be an incentive payment.

[See Appendix D for an estimate of potential savings to the Medicare program should one of these incentive options be implemented.]

Sections 1814 (b) (1) and 1814 (b) (3) (A) of the Social Security Act require contractors be reimbursed only for the "reasonable cost" or "customary charge" for the services rendered. If an incentive program is implemented as a demonstration project and is implemented nationally, it might be necessary to modify this law.

In order for any of these incentive systems to be effective, the method of measuring achieved savings must be reliable. The next two recommendations address this problem.

The HCFA should modify the CPEP standards to evaluate carriers on their MSP identification, recovery, and educational efforts.

The recovery of overpayments created by not properly identifying primary payment sources other than Medicare is not a priority for the carriers. This results in a substantial loss to the Medicare program. The CPEP standards should be modified to emphasize the importance of identifying and recovering these overpayments.

The HCFA should provide clear and uniform procedures for counting MSP savings.

We found inconsistencies in the methods used to count MSP savings. We recommend that HCFA clarify the procedures currently used to count and report

these savings. We are not recommending a method, but we do recommend that the procedures used by all carriers be consistent.

APPENDIX A

MEDICARE SECONDARY PAYER LEGISLATION

TITLE OF LAW	PUBLIC LAW	ENACTMENT DATE	EFFECTIVE DATE	DESCRIPTION
Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)	97-248	09-03-82	01-01-83	TEFRA made Medicare benefits secondary if the employee or spouse is age 65 through 69 covered by an EGHP and the employer has at least 20 employees.
Deficit Reduction Act of 1984 (DEFRA)	98-369	07-18-84	01-01-85	DEFRA broadened the definition of working spouse by including spouses age 65-69 of employed individuals under age 65, thereby removing the lower age limit.
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)	98-272	04-06-86	05-01-86	COBRA further broadened the definition of working aged by removing the limitation of age 70 and older.
Omnibus Budget Reconciliation Act of 1986 (OBRA)	99-509	10-21-86	01-01-87	OBRA made Medicare items and services secondary for payment if the disabled beneficiary or spouse is working and covered under an EGHP.

APPENDIX B

PREVIOUSLY PUBLISHED REPORTS

1. Priority Audit Memorandum - Survey of the Tax Equity and Fiscal Responsibility Act of 1982 - March 7, 1984, Control Number: ACN-03-42009

2. Medicare Secondary Payer Provision End-Stage Renal Disease - Program Inspection Report - August 24, 1984, Control Number: 1-07-4001-14

3. Medicare Secondary Payer Provision End-Stage Renal Disease - South Dakota - November 20, 1984, Control Number: 1-08-4009-14

4. Medicare Secondary Payer Provision End-Stage Renal Disease - Colorado - December 4, 1984, Control Number: 1-08-4001-14

5. Medicare Secondary Payer Provision End-Stage Renal Disease - Program Inspection Report - April 3, 1985, Control Number: 1-07/08-4002-14

6. Medicare Secondary Payer Provision Automobile Medical and No-Fault Insurance - North Dakota - May 1, 1985, Inspection Control Number: 03-08-5001-14

7. Program Inspection of Medicare as a Secondary Payment Source for Beneficiaries with End-Stage Renal Disease in the State of Oregon - May 10, 1985, Inspection Control Number: 3-10-4008-14

8. Medicare as Secondary Payer for Medical Services Related to Automobile Accidents in Massachusetts -June 1985, Control Number: 1-01-4105-31

9. Medicare as a Secondary Payer for Medical Services Related to Automobile Accidents in Massachusetts - Boston - June 1985, Control Number: 1-01-4105-32

10. Report by the Comptroller General of the United States. The Congress Should Consider Amending the Medicare Secondary Payer Provisions to Include Disability Beneficiaries - September 30, 1985, Control Number: GAO/HRD-85-102

11. Medicare Secondary Payer Provision Automobile Liability and Medical Insurance - State of Missouri -Program Inspection Report - December 1985, Control Number: 3-07-5001-32

12. Medicare Secondary Payer Provision Automobile Medical and No-Fault Insurance - State of Colorado - Program Inspection Report - December 1985, Control Number: 3-08-5002-14

13. Medicare Secondary Payer Provision Credit Balances in Medicare Beneficiary Hospital Accounts, Control Number: OPI-85-070-040

14. Medicare Secondary Payer Provision Working Aged in Missouri - July 1986, Control Number P-07-86-00079

15. Medicare Secondary Payer Provision Working Aged in Colorado - July 1986, Control Number: P-07-86-00071

16. OIG Audit Report - Medicare Overpayments for Services Provided to Beneficiaries with End-Stage Renal Disease - April 28, 1987, Control Number: A-10-86-62003

17. OIG Audit Report - Retirees of Exempt State and Local Governments Could Cost Medicare $12.8 Billion over the Next 5 Years - September 10, 1987, Control Number: CIN A-09-86-62050

18. Amending the Medicare Secondary Payer Provision for ESRD Beneficiaries Could Save the Medicare Program $3 Billion Over the Next 5 Years - December 1, 1987, Control Number: CIN-A-10-86-62016

19. Medicare as a Secondary Payment Source - End-Stage Renal Disease - January 1988, Control Number: OAI-07-86-00092

20. Medicare as a Secondary Payment Source - January 1988, Control Number: OAI-07-86-00017

21. Medicare as a Secondary Payment Source: Medicare Beneficiaries Covered By Employer Group Health Plans - February 1988, Control Number: OAI-07-86-00091

22. Nationwide Review of Medicare as Secondary Payer for the Period September 1, 1983 through November 30, 1985, Control Number: CIN A-10-86-62005

23. Medicare: Incentives Needed to Assure Private Insurers Pay Before Medicare - November 1988, Control Number: GAO/HRD-89-191

24. Management Advisory Report: Medicare as Secondary Payer -- A Restitution Proposal, Control Number: AO-12-89-00002

25. Management Advisory Report: More Complete Employer Group Health Plan Information is Needed to Administer the Medicare Secondary Payer Program, Control Number: A-09-89-00100

26. Draft Management Advisory Report: MSP Survey - Contractors Questionnaire, Control Number: A-09-89-00151

27. Management Advisory Report: Medicare Secondary Payer: Unrecovered Funds (OEI-07-90-00764)

APPENDIX C

PRIORITY LISTS FOR CARRIERS' MSP ACTIVITIES*

Required tasks

1. Process prepayment recoveries. These recoveries should be processed for ongoing operations such as Working Aged, Workers' Compensation, Automobile Medical, Liability and No-fault, End Stage Renal Disease, and disabled.

2. Develop first claims submitted by a disabled individual and the first claim submitted by individuals ages 65 and 66. The results of the development must be incorporated into the regional data exchange system (RDES).

3. Operate and maintain the standardized software systems, and participate fully and completely in the RDES.

Tasks that should be complete to the extent that funds are available

1. Develop any new leads in any MSP area.

2. Process suspected cost avoidance claims (claims with "Y" trailers or indications of other insurance coverage from the RDES).

3. Recover mistaken prior payments or provide recovery information to lead contractor as appropriate.

4. Maintain outreach activities at the FY 1989 level.

* These priorities were communicated to HCFA regional offices in November 1989. Carriers were often notified verbally of these priorities but written notification was not uniform. Some carriers were never provided with these priority lists.

APPENDIX D

INCENTIVE PROGRAM OPTIONS

The following example represents potential savings to the Medicare program if an incentive program is established. All calculations are based on national figures for FY 1989 (the most recent fiscal year).

Return on Investment (ROI) for carriers (prior to FY 1990 reductions) = 14:1

Total Savings by carriers = $554,920,413

OPTION A:

Total Savings X Reimbursement Rate = Payment to Carriers

$554,920,413 X .05 (5%) = $27,746,020

The savings of over $27 million would be used by the carriers to supplement their MSP activities. The following calculation illustrates total Medicare program savings that could be achieved if this program is implemented.

Incentive payments to Carriers X ROI - Payment to Carriers = Potential Medicare Program Savings

($27,746,020 X 14) - $27,746,020 = $360,698,269

Even if the ROI decreased with increased expenditures, as long as it remains positive the program will remain cost effective.

OPTION B:

This option would provide additional funding to encourage carriers to make recoveries on the backlog of claims created by the FY 1990 budget reduction.

Savings for this option would equal the savings in Option A plus recoveries made on claims that were previously paid inappropriately. This potential savings is unknown because there is no accurate count or estimate of these potential recoveries.

OPTION C:

This option provides an added incentive to the carriers to use a portion of the funds in any area of the corporate operation.

Total Savings X Reimbursement Rate = Payment to Carriers

$554,920,413 X .03 (3%) = $16,647,612 (to supplement MSP unit activities)

$554,920,413 X .02 (2%) = $11,098,408 (incentive payment)

Payment to Carrier X ROI - Payment to Carriers = Total Medicare Savings due to Incentives

($16,647,612 X 14) - ($16,647,612 + $11,098,408) = $205,320,548

OPTION D:

Total Savings - FY 1989 Savings Goal = Amount Saved Above Goal

$554,920,413 - $447,109,000 = $107,811,413

Amt. Saved Above Goal X Reimbursement Rate = Payment to Carrier

$107,811,413 X .15 (15%) = $16,171,712 (to supplement MSP unit activities)

$107,811,413 X .10 (10%) = $10,781,141 (incentive payment)

Payment to Carrier X ROI - Payment to Carrier = Total Medicare Savings due to Incentives

($16,171,712 X 14) - ($16,171,712 + $10,781,141) = $199,451,115

Chairman PICKLE. Mr. Mangano, I will have questions for you, but we are going to proceed with the list of witnesses to make statements.

I would make an inquiry of you, why did the Government not proceed with the law suit against the company which was intentionally making payments and they knew it at the time?

Mr. MANGANO. I am going to let Bob Simon answer that.

Mr. SIMON. Mr. Chairman, we did conduct——

Chairman PICKLE. Talk into the microphone, please.

Tell me why the Government didn't proceed with that.

Mr. SIMON. There was no question in our minds that they did intentionally not pay according to their responsibility. However, we were not able to prove that they crossed the threshold of criminality.

Chairman PICKLE. Speak into the microphone.

Mr. SIMON. As I was saying, we did conduct an exhaustive investigation into that case. We found in our opinion that that insurance company intentionally did not pay according to their responsibilities. However, we weren't able to cross the threshold of criminality and, therefore, we couldn't prove corporate intent on a criminal level.

The Justice Department declined to prosecute it in two judicial districts.

Chairman PICKLE. Did you represent the Government in that suit?

Mr. SIMON. My organization conducted the investigation, yes.

Chairman PICKLE. I wish you would furnish the subcommittee your reasoning why you did not proceed with that particular suit.

Mr. SIMON. Certainly.

Chairman PICKLE. After this hearing, would you do that?

Mr. SIMON. Yes, sir.

[The information follows:]

U.S. Department of Justice

United States Attorney
Northern District of Georgia

Suite 1800 Richard Russell Building
75 Spring Street, S.W.
Atlanta, Georgia 30335

Telephone: (404) 331-6954

April 26, 1990

Mr. James M. Cottos
Regional Inspector General
for Investigations
U.S. Department of Health
and Human Services
P.O. Box 2288
Atlanta, Georgia 30301

Re: Provident Life and Accident Insurance Company

Dear Mr. Cottos:

After careful consideration, we have decided to decline prosecution of the above-referenced case. Because of the lack of affirmative misrepresentations to the government by Provident Life and Accident Insurance Company (Provident), the failure of the government to implement the provisions of TEFRA which made Medicare the secondary payor of the claims of the working aged, potential defenses by Provident, and other matters discussed with you, we feel that this matter is not appropriate for criminal prosecution. We note that the government's claims against Provident are being currently pursued in civil litigation.

If you have any questions concerning this matter, please feel free to call me.

Yours truly,

RIMANTAS A. RUKSTELE
UNITED STATES ATTORNEY

Gerrilyn G. Brill

GERRILYN G. BRILL
ASSISTANT UNITED STATES ATTORNEY
CHIEF, FRAUD SECTION

4-89-004558-9

Chairman PICKLE. Thank you very much.

The next witness will be Janet Shikles, Director of Health Financing and Policy Issues of the General Accounting Office.

Ms. Shikles.

STATEMENT OF JANET L. SHIKLES, DIRECTOR, HEALTH FINANCING AND POLICY ISSUES, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY TERRY DAVIS, ASSISTANT DIRECTOR, MEDICAID AND MEDICARE

Ms. SHIKLES. Thank you, Mr. Chairman, and members of the subcommittee.

I want to introduce Terry Davis, who is with me today. He is an Assistant Director in our Human Resources Division.

We are very pleased to be here today to discuss our continuing efforts to assess the effectiveness of the Medicare secondary payer provisions.

The MSP provisions are intended to assure that insurers, whose coverage is primary, pay claims before Medicare. Under these provisions, Medicare claims processing contractors have two interrelated responsibilities. The first is to identify other insurers, and thus prevent inappropriate Medicare payments, and the second is to identify and recover mistaken payments that were made prior to determining that the beneficiary had other insurance.

My testimony today focuses on the second MSP responsibility, part B contractors or carriers' efforts to recover mistaken Medicare payments after determining that beneficiaries have other insurance.

The results of our work to date suggest that this aspect of the MSP program is plagued with problems. First, carrier systems problems and relaxed payment controls have contributed to the increased volume of mistaken Medicare payments that must be recovered. Second, because of MSP funding cutbacks, carriers have done little to collect mistaken payments from other insurers since October 1, 1989.

HCFA has no reliable information on the size of the backlog or the total dollars associated with mistaken payments. However, based on our work to date, we believe that carriers have paid hundreds of millions of dollars, and perhaps more, than that should be recovered from other insurers.

A recently initiated Internal Revenue Service/Social Security data match and a Department of Health and Human Services' regulation make it imperative that actions are taken immediately to address this problem. The data match could add several million more claims to the existing backlog of mistaken Medicare payments.

Further, the HHS regulation limits the time that contractors have to initiate recovery action after they identify another insurer. Thus, unless contractors are given the necessary resources to begin recovering the mistaken payments, hundreds of millions of dollars owed to Medicare may never be recovered.

We believe that carriers should be adequately funded to recover these mistaken payments and that additional funds will return considerably more than the dollars spent.

First, I want to tell you a little bit about the work we have been doing. We began it in January 1990 to determine what effect the funding cutbacks have had on carrier MSP activities. Based on our preliminary results, it appears that even when carriers have information which indicates that Medicare beneficiaries have other insurance coverage, they are not routinely reviewing previously paid Medicare claims to identify and collect the refunds due from private insurers.

In addition, we have identified situations where for various reasons carriers have paid claims totaling millions of dollars after learning that the beneficiaries had primary coverage.

I am going to give you a few examples of our concerns. At Blue Cross and Blue Shield of Maryland, we found a large inventory of potential mistaken Medicare payments, totaling about $8.8 million, that were not being recovered. These payments were the responsibility of other insurers.

Blue Cross and Blue Shield of Maryland, as a private insurer, may be responsible for about $4 million, or almost half of the total mistaken payments.

While it is difficult to determine all the contributing factors, we believe that funding cutbacks for MSP activities hampered the contractors attempts to recover part B mistaken payments.

The contractor's funding for MSP activities under part B actually increased in 1989 and then was cut by about 51 percent, from over $700,000 to about $363,000. After we did our work at the Maryland contractor, HCFA then gave them some additional funding, and they have begun to recover some of the mistaken payments. Our latest data suggests they have recovered about $2 million.

We have also done work at other carriers. The other carriers, however, did not have a listing of mistaken payments. We had to develop a sample at each of these carriers.

At the carrier for Arizona and Nevada, we selected a random sample of 154 beneficiaries who were identified as having other insurance. Based on this sample, we found that Medicare paid one or more claims totaling about $83,000 for 71 of the beneficiaries.

While our work is not yet complete, we estimate that this carrier may have paid Medicare claims of about $5.5 million that should have been paid by other insurers.

Due to the lack of resources, the carrier is not attempting to recover mistaken payments. We estimate that this carrier could recover $17 for every dollar spent pursuing MSP mistaken payments.

We also did work at two carriers in California. Again, we had to develop samples because they didn't have a listing of mistaken payments. In the process of developing our sample at one of the California carriers, we found another problem. Due to a conversion to a new claims processing system at this carrier, a number of new mistaken payments occurred. What happened is that during a 2-week period when they were converting, they deleted information on about 50,000 beneficiaries that had primary insurance coverage. Therefore, during that period we believe the carrier paid claims that should have been paid by other insurers.

The carrier told us that they are not attempting to recover the mistaken payments. Further, we are not certain that they have totally fixed the problem even now.

At the other California carrier, again, we had to develop a sample. We are just in the process of analyzing the data.

However, we can give you an example of some of the problems. Our analysis of beneficiary payment files showed for a 2-day period that 63 or 70 percent of the beneficiaries sampled had submitted one or more prior claims totaling about $76,500. One beneficiary alone submitted 153 claims totaling about $42,000 that may have been the responsibility of another insurer. As of October 1989, the carrier discontinued efforts to recover any of these mistaken payments.

We believe that HCFA does not regularly collect nor require contractors to keep management information on the number of mistaken payments made or the dollar value potential due back to Medicare. HCFA recently surveyed the Medicare contractors on that matter, but the results are unreliable.

We believe that the part B claims inventory alone probably numbers in the millions. As cited in our June testimony before the Subcommittee on Health, we estimated that the dollar value is at least over several hundred million dollars in lost payments.

HCFA has recently reallocated $3 million from other parts of the contractors' 1991 budget to attempt to recover some of these payments. They estimate that this will recover about $50 million, a small portion of what really should be collected.

As I also mentioned, we are also concerned that this recently initiated IRS/SSA data match will add several million more claims to the existing backlog of mistaken Medicare payments. Required by OBRA of 1989 and 1990, the data match between IRS and SSA is intended to help identify beneficiaries who have other insurance coverage. This project could add significantly to the already large inventory of mistaken Medicare payments that are not now being collected.

The fiscal year 1992 budget requests $25.8 million to fund carrier MSP activities. This includes funds to develop the mistaken payments that are supposed to be identified by the data match. This is a small increase over the fiscal year 1991 budget, but we are concerned that carriers are still going to receive about $10 million less than they received for this activity in fiscal year 1989.

Finally, effective November 13, 1989, HHS regulations limit the time of reinitiating recovery actions of mistaken payments after another insurer is identified. Thus, the clock may have already started ticking on thousands of Medicare claims where carriers have identified another insurer but are not seeking recovery.

Further, HCFA officials told us that the primary insurer will be considered identified at the time the contractors receive their individual output tapes from the data match. Unless timely recovery actions are initiated on these mistaken payments, Medicare may be unable to recover millions of dollars of claims that other insurers are responsible for paying.

In conclusion, in a time when Medicare costs are increasing rapidly, we believe that Medicare carriers should be attempting to recover the hundreds of millions of dollars potentially owed to the

Medicare program by other insurers. We believe HCFA should work with each contractor to determine the full scope of the problem, develop an estimate of the resources needed to correct it, and establish a plan including milestones, for seeking recoveries.

HCFA must decide the most appropriate method of funding contractor efforts to recover mistaken Medicare payments. Perhaps this can be done through a combination of redirecting existing resources and requesting additional MSP funds. It is clear to us that this MSP activity is very cost-effective, and in our opinion, every dollar spent for this effort is a wise investment.

Mr. Chairman, this concludes my prepared statement.

Thank you.

[The prepared statement follows:]

United States General Accounting Office

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Medicare: Millions in Potential Recoveries Not Being Sought by Contractors

Statement of
Janet L. Shikles, Director
Health Financing and Policy Issues
Human Resources Division

Before the
Subcommittee on Oversight
Committee on Ways and Means
House of Representatives

GAO/T-HRD-91-8

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss our continuing efforts to assess the effectiveness of the Medicare Secondary Payer (MSP) provisions.

The MSP provisions are intended to assure that insurers,[1] whose coverage is primary, pay claims before Medicare. Under these provisions, Medicare claims processing contractors have two interrelated responsibilities: (1) to identify other insurers and, thus, prevent inappropriate Medicare payments, and (2) to identify and recover mistaken payments that were made prior to determining that the beneficiary had other insurance.

Over the past several years, we have issued a number of reports on how well contractors performed the first of their MSP responsibilities. We concluded that, for a number of reasons, they were not very effective at identifying other insurers that should pay before Medicare. While problems remain, recent legislative requirements could enhance contractors' ability to identify primary payers and help avoid future mistaken payments.

This testimony focuses on the second MSP responsibility--part B contractors' (carriers) efforts to recover mistaken Medicare payments after determining that beneficiaries have other insurance. The results of our work to date suggest that this aspect of the MSP program is also plagued with problems. First, carrier systems problems and relaxed payment controls have contributed to the increased volume of mistaken Medicare payments that must be recovered. Second, because of MSP funding cutbacks carriers have done little to collect mistaken payments from other insurers since October 1, 1989.

The Health Care Financing Administration (HCFA) has no reliable information on the size of the backlog or the total dollars associated with mistaken payments. However, based on our work to date, we believe that carriers have paid hundreds of millions of dollars that should be recovered from other insurers.

A recently-initiated Internal Revenue Service (IRS)/Social Security Administration (SSA) data match and a Department of Health and Human Services (HHS) regulation make it imperative that actions are taken immediately to address this problem. The data match could add several million more claims to the existing backlog of mistaken Medicare payments. Further, the HHS regulation limits the time that contractors have to initiate

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[1]We use the term "insurer" to mean all liable third parties, including insurance companies, third-party administrators, and "self-insured" employer health benefit plans.

recovery action after they identify another insurer. Thus, unless contractors are given the necessary resources to begin recovering the mistaken payments, hundreds of millions of dollars owed to Medicare will never be recovered.

We believe that carriers should be adequately funded to recover these mistaken payments and that additional funds will return considerably more than the dollars spent.

MEDICARE AS SECONDARY PAYER

Medicare is administered by HCFA within HHS. HCFA contracts with insurance companies to process and pay claims for covered services. The insurance companies--called intermediaries under part A and carriers under part B--are expected to pay Medicare claims totaling more than $115 billion in fiscal year 1991.

When the Congress enacted the Medicare program in 1965, it made Medicare the secondary payer for beneficiaries also covered by workers' compensation. The Congress expanded the MSP provisions several times between 1980 and 1987 making Medicare the secondary payer to certain employer-sponsored group health insurance plans and to automobile and other liability insurance plans.

Medicare contractors are generally required to take two actions after determining that the beneficiary has other insurance. First, they enter a "flag" or edit into the claims processing system so that future claims will be denied by Medicare and sent to the beneficiary's insurer. Second, they are required to research the beneficiary's claims history file to determine if Medicare has paid claims after the effective date of the other insurance coverage and, if so, attempt recovery.

Our earlier reports recommended actions to improve identification of other insurers under the MSP program.[2] Specifically, these reports concluded that Medicare contractors have little incentive to ensure that Medicare pays only after other payers. In part, this is because some insurance companies that serve as Medicare claims processing contractors may have a conflict of interest because they could be the primary insurer for Medicare beneficiaries. We made a number of recommendations to address this problem.

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[2]Medicare: More Hospital Costs Should Be Paid by Other Insurers (GAO/HRD-87-43, Jan. 29, 1987) and Medicare: Incentives Needed to Assure Private Insurers Pay Before Medicare (GAO/HRD-89-19, Nov. 29, 1988).

The Administration has reduced the funds available to contractors to carry out their MSP activities. This was particularly true for part B MSP funding which was cut from about $36 million in fiscal year 1989 to about $15 million in 1990, a 60-percent reduction.

MILLIONS IN POTENTIAL RECOVERIES NOT BEING SOUGHT BY MEDICARE CONTRACTORS

We began work in January 1990 to determine the effect of funding cutbacks on carrier MSP activities. We have completed our work at Blue Cross and Blue Shield of Maryland, the carrier for that state, and at Aetna Life and Casualty, the carrier for Arizona and Nevada. We are continuing work at two California carriers--Transamerica Occidental Life Insurance and Blue Shield of California--and have just begun at Florida Blue Cross and Blue Shield.

Based on our preliminary results, it appears that even when carriers have information which indicates that Medicare beneficiaries have other insurance coverage, they are not routinely reviewing previously paid Medicare claims to identify and collect refunds due from private insurers. In addition, we have identified situations where, for various reasons, carriers have paid claims totaling millions of dollars after learning that beneficiaries had primary coverage.

Following is a summary of our work at three of the carriers. Information on the others is contained in attachment I.

Blue Cross and Blue Shield of Maryland

As discussed in our recently issued report on Blue Cross and Blue Shield of Maryland, we found a large inventory of potential mistaken Medicare payments that were not being recovered.[3] The contractor, through MSP investigative efforts, developed information--including policy numbers--that showed beneficiaries had other insurance that was potentially responsible for the payments.

Using the contractor's handwritten ledgers for this inventory, we developed a listing of 3,059 cases for which Medicare had paid about $8.8 million during the period 1983 to 1989. We found that a relatively few cases account for a

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[3]Medicare: Millions in Potential Recoveries Not Being Sought by Maryland Contractor (GAO/HRD-91-32, Jan.25, 1991). Blue Cross and Blue Shield of Maryland is the Medicare contractor for part A services in Maryland and the District of Columbia and for part B services in most of Maryland.

significant portion of these payments. For example, the 128 cases that involve payments of $15,000 or more account for about $3.6 million or 40.8 percent of the mistaken payments. (See attachment II for a listing of the 10 largest cases.)

We also found that 13 insurers are each potentially responsible for more than $100,000 of the payments. Blue Cross and Blue Shield of Maryland is also a private insurer and may be the primary payer for $4.1 million, or almost half the total mistaken payments identified.

As stated earlier, the contractor was doing little to recover the funds from other insurers before our visit. While it is difficult to determine all the reasons for this, we believe that cutbacks in funds for MSP activities hampered the contractor's attempts to recover part B mistaken payments. The contractor's funding for MSP activities under part B increased in fiscal year 1989, but was reduced by about 51 percent in fiscal year 1990-- from $738,385 to $363,900. This was part of a nationwide reduction in MSP funding.

Because of our work at the Maryland contractor, HCFA provided additional fiscal year 1990 funding to the contractor to begin collecting the mistaken Medicare payments. The contractor used our listing and has taken action on about 950 of the larger dollar cases. Since the beginning of fiscal year 1991, the contractor has reduced its recovery efforts and is currently reviewing about 10 cases per week. According to contractor officials, about $2.3 million had been repaid to Medicare as of February 15, 1991.

Aetna Life and Casualty Company

Aetna processes part B claims for both Arizona and Nevada. We found that, unlike the Maryland carrier, Aetna did not research its files to identify mistaken Medicare payments after learning that beneficiaries had other insurance. Carrier officials stated that they discontinued such efforts after the October 1989 MSP budget cut because they lacked the resources to identify mistaken payments and seek recoveries. Thus, Aetna had no inventory of mistaken payments for us to review.

To estimate the dollar value of mistaken Medicare payments at this carrier, we selected a random sample of 154 beneficiaries identified as having other insurance. We found that Medicare paid one or more claims totaling about $83,000 for 71 of the 154 beneficiaries in our sample. As noted in our Maryland work, a significant portion of these potential recoveries is concentrated in a relatively few cases. About $40,000, or nearly one-half of the mistaken payments in our sample, was contained in about 7 percent of the claims paid.

Based on the results of our sample, we estimate that this carrier may have paid claims of about $5.5 million with Medicare funds that should have been paid by--and recovered from--private insurers. We estimate that this carrier could recover $17 for every dollar spent pursuing MSP mistaken payments.

Blue Shield of California

We are also using a random sample for our analysis at Blue Shield of California. We are still in the early stages of our evaluation, in part because we have experienced a number of problems in obtaining payment history data and other information on the cases selected for review.

However, we believe that a conversion to a new claims processing system in August 1990 has added to the number of mistaken Medicare payments made by this carrier. During the conversion, information on 50,000 beneficiaries with primary insurance coverage was deleted for a 2-week period. Thus, the carrier may have paid claims that should have been paid by other insurers.

On February 19, 1991, carrier officials told us they do not know the dollar value of, nor are they attempting to recover, the mistaken payments made during this period. They said that measures have been taken to reenter the deleted beneficiary insurance information but have not provided us with specific details on these measures. However, we identified several other similar cases which indicate that the problem has not been fully corrected.

SIZE OF EXISTING INVENTORY
OF MISTAKEN PAYMENTS IS UNKNOWN

HCFA does not regularly collect--nor require contractors to keep--management information on the number of mistaken payments made or the dollar value potentially due back to Medicare. HCFA recently surveyed the Medicare contractors on this matter, but the results are unreliable.

We believe that the part B claims inventory alone probably numbers in the millions. As cited in our June 14, 1990 testimony given before the Subcommittee on Health, House Committee on Ways and Means, we believe the dollar value of funds that could be collected from insurers is at least $200 million.[4]

HCFA recently reallocated $3 million from other parts of the contractors' 1991 budget to fund efforts to pursue and recover

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[4]Medicare: Effects of Budget Reductions on Contractor Program Safeguard Activities (GAO/T-HRD-90-42, June 14, 1990).

mistaken Medicare payments. HCFA expects to recover about $50 million, a small portion of the dollars associated with the entire inventory of MSP claims.

DATA MATCH COULD IDENTIFY ADDITIONAL MISTAKEN MEDICARE PAYMENTS THAT SHOULD BE RECOVERED

A recently-initiated IRS/SSA data match could add several million more claims to the existing backlog of mistaken Medicare payments. Required by the Omnibus Budget Reconciliation Acts of 1989 and 1990, the data match between IRS and SSA is intended to help identify beneficiaries who have other insurance coverage. IRS records for tax years 1987 through 1989 were used to identify Medicare beneficiaries and their spouses who were employed. The SSA master earnings files were used to identify the employers, and the results have been provided to HCFA.

Employers now must be contacted to determine if they provide health insurance to Medicare beneficiaries and, if so, the effective date of the coverage. HCFA awarded a contract to Group Health Incorporated (GHI), a Medicare carrier in New York, to obtain the insurance information. As information is obtained, GHI will enter beneficiary insurance data into the automated claims processing system used by Medicare contractors to prevent future claims payment. HCFA officials told us that the cost of the contract will be $14.2 million over a 3-year period.

HCFA also will use beneficiary insurance data to determine if Medicare mistakenly paid claims while the beneficiary had other coverage. Using its claims history file, HCFA will provide Medicare contractors with listings of mistaken payments that should be developed and recovered from other insurers. Thus, this project could add significantly to an already large inventory of mistaken Medicare payments that are not being collected.

Excluding the funds for the GHI contract ($6.6 million), the fiscal year 1992 budget requests $25.8 million to fund carrier MSP activities. This includes funds to develop the mistaken payments that will be identified by the data match project. While this is a small increase over the 1991 funding level, carriers will receive about $10.2 million less for MSP in 1992 than in fiscal year 1989, the year before the major budget cut.

HHS REGULATIONS LIMIT TIME FOR RECOVERING MISTAKEN PAYMENTS

Effective November 13, 1989, HHS regulations limit the time for initiating recovery of mistaken payments. These regulations state that contractors must initiate recovery action within 15 to 27 months after identifying another insurer as being primary or

the insurer will no longer be held liable for the amount mistakenly paid by Medicare. Thus, the clock may have already started ticking on thousands of Medicare claims where carriers have identified another insurer (after November 13, 1989) but are not seeking recovery. Further, HCFA officials told us that the primary insurer will be considered "identified" at the time the contractors receive their individual output tapes from the IRS/SSA data match. Unless timely recovery actions are initiated on these mistaken payments, Medicare may be unable to recover millions of dollars of claims that other insurers are responsible for paying.

CONCLUDING REMARKS

In a time when Medicare costs are increasing rapidly, we believe that Medicare carriers should be attempting to recover the hundreds of millions of dollars potentially owed to the Medicare program by other insurers. The IRS/SSA data match and HHS regulations highlight the need to adequately fund carrier operations so that they can carry out this important MSP function. We are pleased to see that the 1992 budget request contains an increase for carrier MSP activities. However, this funding may be insufficient to address the existing backlog of mistaken payments, as well as the additional workload that will be created by the data match.

As was the case with the Maryland carrier, we believe that HCFA should work with each contractor to (1) determine the full scope of the problem, (2) develop an estimate of the resources needed to correct it, and (3) establish a plan, including milestones, for seeking recoveries. HCFA must decide the most appropriate method of funding contractor efforts to recover mistaken Medicare payments. Perhaps this can be done through a combination of redirecting existing resources and requesting additional MSP funds. It is clear that this MSP activity is very cost effective and, in our opinion, every dollar spent for this effort is a wise investment.

* * * *

Mr. Chairman, this concludes my prepared statement. My colleagues and I will be pleased to answer any questions you and the other members of the Subcommittee may have.

ATTACHMENT I

ATTACHMENT I

PRELIMINARY RESULTS OF GAO
WORK AT TWO MEDICARE CARRIERS

Transamerica Occidental Life Insurance

At Occidental, one of the two California carriers, the situation was similar to that at Aetna. According to carrier officials, prior to the October 1989 budget reductions, MSP staff would research carrier payment files to identify mistaken Medicare payments and seek recovery when beneficiaries had other insurance. Like Aetna, Occidental has discontinued such efforts.

We have not completed our analysis of the files for a sample of 350 beneficiaries and, thus, are unable to estimate the amount of uncollected mistaken payments at Occidental. However, to illustrate the magnitude of the problem, we developed information on 89 beneficiaries identified during a two-day period in September 1990 as having other insurance. The carrier did not review its payment history for these beneficiaries to determine if another insurer, rather than Medicare, should have paid prior claims. Our analysis showed that 63, or 70 percent of the beneficiaries sampled, had submitted one or more prior claims totaling about $76,500. For one beneficiary alone, we identified 153 claims totaling about $42,000 that may have been the responsibility of another insurer.

Blue Cross and Blue Shield of Florida

We have just begun our work at Blue Shield of Florida. However, carrier officials told us that a HCFA directive--implemented during the period October 1, 1989 to September 30, 1990--coupled with a system limitation significantly increased the number and amount of Medicare payments that should have been made by other insurers.[1]

They explained that before that period, on claims of $50 or more, the carriers were required to determine if beneficiaries had other insurance coverage. Because of the budget cutbacks, HCFA raised the threshold for claim development from $50 to $250. Claims of less than $250 were automatically paid without determining if the beneficiary had other insurance coverage.

Florida carrier officials told us that, before October 1990, their processing system did not have the capability to positively

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[1]The other carriers included in our review did not implement the directive.

identify beneficiaries who had previously reported other insurance coverage. As a result, the carrier had to continually redevelop insurance coverage information by sending letters of inquiry to the beneficiaries before claims could be paid. Thus, the HCFA directive affected a much larger volume of claims at the Florida carrier than might have been the case elsewhere.

Carrier officials advised HCFA that about 360,000 claims representing about $34 million were paid automatically during the time the HCFA directive was in effect. It is highly probable that many of these claims were for beneficiaries who had previously reported other insurance coverage and, thus, would have been denied had the carrier's system contained an insurance indicator.

Carrier officials told us that, as of October 1990, they were developing all MSP claims over $50 and an insurance indicator was added to their system. Since we have just initiated our work at this carrier we have not verified these changes.

ATTACHMENT II

ATTACHMENT II

TEN LARGEST MEDICARE CASES THAT
SHOULD BE RECOVERED BY MARYLAND CONTRACTOR

Insurer	Part A Dollars	Part A Claims	Part B Dollars	Part B Claims	Total Dollars	Total Claims
Blue Cross/Blue Shield of Maryland	124,591.41	5	12,290.82	50	136,882.23	55
Blue Cross/Blue Shield of Maryland	97,419.02	19	11,118.31	68	108,537.33	87
Blue Cross/Blue Shield of Pennsylvania	83,082.00	27	8,339.30	93	91,421.30	120
I.L.A Benefit Fund	62,351.83	4	9,607.36	29	71,959.19	33
Columbia Freestate	67,661.51	20	1,644.27	59	69,305.78	79
Blue Cross/Blue Shield of Maryland	59,118.66	78	7,377.07	79	66,495.73	157
Carefirst	54,912.38	7	10,764.46	62	65,676.84	69
Blue Cross/Blue Shield of Maryland	57,732.01	7	71.12	3	57,803.13	10
Mass Mutual	49,212.20	9	7,702.91	62	56,915.11	71
Columbia Freestate	44,730.10	5	4,947.61	0	49,677.71	5
Total	700,811.12	181	73,863.23	505	774,674.35	686

Chairman PICKLE. I wish you would later submit to the subcommittee the manner at which you arrived at the $200 million figure. There has been $900 million estimated by another. Submit to our subcommittee, if you will please, how your group arrived at that figure, will you.

Ms. SHIKLES. Yes, I will.

[The following was subsequently received:]

Our estimate of $200 million is based on work we did at several part B Medicare carriers. We identified about $17.2 million in MSP overpayments at these carriers which, if representative of all part B carriers, would equate to about $200 million nationwide. I might add that HCFA has also estimated that there is about $200 million in unrecovered mistaken primary payments.

I want to emphasize that our estimate is for only those Medicare beneficiaries that carriers have identified as having other insurance and mistakenly paid their claims. In addition, HHS OIG and prior GAO reports have stressed the need for better information on identifying other insurers that may be the primary payers for services provided to Medicare beneficiaries. OIG estimates, which are significantly higher than ours, are based on unidentified MSP cases for both part A and B Medicare beneficiaries.

Chairman PICKLE. Our next witness will be Jill Jacoby, manager of the Medicare secondary payer unit of Blue Cross and Blue Shield of Maryland.

STATEMENT OF JILL JACOBY, MANAGER, MEDICARE SECONDARY PAYER UNIT, BLUE CROSS AND BLUE SHIELD OF MARYLAND

Ms. JACOBY. Mr. Chairman and members of the subcommittee, with me today is Miss Susan Howell, supervisor of the part A Medicare secondary payer unit. We thank you for the opportunity to discuss our role as a Medicare contractor and our activities related to the Medicare secondary payer program.

As a Medicare contractor, we operate under very specific HCFA directives. HCFA audits various aspects of our operation anywhere from monthly to annually. Our MSP program has achieved a high level of success, saving the Government over $45 million in fiscal year 1990. We saved $32 for every dollar we spent.

We achieved savings through two basic activities: First, obtaining other payer information before paying a claim; second, using the information gathered in the first process to identify prior erroneous payments and recover those dollars.

The success of the part A/MSP program is largely dependent on the institutional provider giving Medicare the appropriate payer information at the time a claim is submitted.

In general, we find that inpatient admitting clerks tend to ask a majority of these questions——

Mr. SUNDQUIST. Excuse me, which page are you on?

Ms. JACOBY. I am using a summary of the written statement.

Mr. SUNDQUIST. Could you give us a copy of that when you leave?

Ms. JACOBY. Certainly. In general, we find that inpatient admitting clerks tend to ask a majority of these questions on a fairly consistent basis.

On the other hand, we have found frequent problems with hospital outpatient registration procedures. This leads to a fundamental problem. If the registration clerk in an outpatient area does not ask all the mandated questions, the billing department does not

have sufficient information to determine just who the primary payer is. The result is that many times the bill is sent to Medicare.

Knowing that we might receive erroneous or no payment information from the hospital, we have in place several other methods of gathering MSP information.

First, HCFA has established an MSP auxiliary record for every beneficiary in the common working file. The common working file, which is also known as CWF, has a beneficiary data base used by all the contractors in a given HCFA region.

All contractors in a region will enter information on beneficiaries who are covered under an employer group health plan or EGHP, so that all other contractors in the region will have access to this same information.

Another source of MSP information is the beneficiary himself. HCFA mandates that when we receive the first claim for a new Medicare beneficiary, we send him an MSP questionnaire which asks questions aimed at determining if another payer exists. Often a beneficiary will contact us after receiving a Medicare explanation of benefits to tell us we should not have paid that claim and to provide us with information we need concerning the other primary payer.

On the part B side of the MSP unit, we must rely on the CWF auxiliary record and the beneficiary, since Medicare regulations do not require physicians to question their patients concerning other potential payers.

There is one other major source of MSP information utilized by both our part A and part B sides, the private side of Blue Cross and Blue Shield of Maryland. They voluntarily provide us with a quarterly report, which lists all the claims they paid on behalf of Medicare beneficiaries and with copies of enrollment forms.

We use the data to capture savings, update our data base and the CWF auxiliary record, and to prevent future erroneous payments. Once we identify a particular claim for which Medicare is not the primary payer, we also want to look at the prior paid claims. This is an elaborate procedure. Our part A standard claims processing system automatically generates a list of prior paid claims whenever we deny a claim for MSP reasons. On the part B side, we manually order a paid claims history.

The list of prior paid claims is placed in a folder and becomes a case. An individual case can involve as many as 100 claims. Each claim has to be reviewed individually.

The process for recovering erroneous payments from hospitals and other part A providers is relatively simple. We notify them in writing of the appropriate primary payer and give them 45 days to submit a claim to that payer. At the end of that period, we subtract the amount due from their weekly remittance.

Recovering a part B payment is much more complicated. We first contact the primary payer, informing it of our erroneous payment, and asking if it has also paid the claim in question.

If it has paid the claim, we attempt to recover our payment from the provider or beneficiary. If the primary payer has not made a payment, we supply it with a copy of the claim and request it to forward the amount owed. Current HCFA policy mandates that we send a series of five demand letters over a span of 150 days. If we

receive no response from the payer or payee, we forward the case to HCFA, who will negotiate a recovery on our behalf.

The actual process of recovering an erroneous payment is more complicated than the payer simply writing a check on demand. All payers request copies of the claims themselves. They, like Medicare, must be certain that the service rendered was medically necessary and covered under the terms of the contract. They also want to determine if a deductible or coinsurance is due. If the payer submits a payment or an explanation of benefits for a payment which has already been made, we must coordinate benefits with Medicare and recoup any overpayments. This process could take several hours for an individual case.

Once the erroneous payment is recovered, the MSP unit must process an adjustment to the original claim. This adjustment is needed to assure Medicare records accurately reflect benefit utilization and appropriately record the savings.

Now I would like to comment on the GAO report. By mid-1988 we had created a backlog of cases. We had been extremely successful in identifying other payers, but we were not sufficiently staffed to investigate claims. In our fiscal year 1989 budget request, we notified HCFA of the backlog and requested five additional case workers. We were given two.

In February 1989, the MSP unit did an inventory of its cases and produced a handwritten list noting the primary payer and the dollar value of the part A and part B claims within each case. The list contains a little over 3,000 cases, totaling $8.8 million.

In 1989, staff from our private side and MSP formed a coordination of benefits work group and began researching the Blue Cross and Blue Shield of Maryland cases. By the end of September, the group had adjudicated 84 cases and Medicare had recovered over $258,000. The fiscal year 1990 budget mandated we eliminate seven case workers, leaving us with 1.5. We were thus forced to greatly reduce case work activities.

GAO first visited us in April 1990. We furnished them with our handwritten inventory, and they in turn produced a computerized listing which ranked the cases by payer and by dollar value. We also shared with the GAO budget documents and correspondence to and from the HCFA regional office concerning case work.

Since the April visit, we have resolved 3.5 million of the cases on the computerized list. We have recovered $2.7 million in erroneous payments and found that Medicare was, in fact, primary for $800,000. Most of this work occurred in September 1990 when HCFA notified us that money from the 1990 contingency fund was available to our MSP unit for erroneous payment recovery during the month of September.

In our fiscal year 1991 budget request, we asked for an additional 5.5 case workers. The budget just received did not provide for additional staff. The MSP part A unit is continuing to work the cases on the GAO list, but they are not working any new cases. The MSP part B unit has ceased case work all together.

While still a young program, MSP has proven to be a valuable payment safeguard. We believe MSP could provide even more value to the Medicare program were it not for certain barriers. In

order to improve the program and save even more trust fund dollars, we offer the following recommendations:

Number one, as effective as our current information gathering methods are, we still frequently find ourselves in a pay and chase situation. If the Social Security Administration were to require every new Medicare beneficiary to complete and submit an MSP questionnaire prior to the issuance of a Medicare card, contractors would have valid primary payer information on file before the first claim was filed, minimizing erroneous payments.

Two, we believe the Federal Government should provide increased consistent funding for the MSP program. At the current 32-to-1 savings ratio, this is one of the best bargains in Medicare.

Finally, we believe that the Federal budget should explicitly count the savings that result from MSP operations as well as other Medicare contractor operations that prevent inappropriate payments. The current budget process, which only counts the cost of administering the MSP program, fails to provide incentives for either Congress or the administration to invest in the sound management of Medicare.

In closing, the Blue Cross and Blue Shield of Maryland MSP unit has proved to be extremely successful in safeguarding the Medicare trust fund. With these changes, it can be even more so. We look forward to your continued interest and support as we work together to improve the administration of the Medicare program. Thank you.

[The prepared statement follows:]

TESTIMONY OF JILL JACOBY
BLUE CROSS AND BLUE SHIELD OF MARYLAND

Mr. Chairman and members of the subcommittee, I am Jill Jacoby, Manager of the Medicare Secondary Payer Unit for Blue Cross and Blue Shield of Maryland. With me today is Susan Howell, Supervisor of the Part A Medicare Secondary Payer Unit. We thank you for the opportunity to discuss our role as a Medicare contractor and our activities related to the Medicare Secondary Payer program.

Let me begin with a brief explanation of Blue Cross and Blue Shield of Maryland's role as a Medicare contractor.

Blue Cross and Blue Shield of Maryland has been the Part A Fiscal Intermediary for institutional providers and the Part B Carrier for physicians and suppliers in Maryland since 1966. In 1988, we became the Fiscal Intermediary for Washington, D.C. providers.

In fiscal year 1990, Blue Cross and Blue Shield of Maryland processed 1.4 million Part A claims and 5.4 million Part B claims and made nearly $2 billion dollars in payments for health care services rendered to 700,000 beneficiaries. We spent just over $20 million to administer the program, an amount equal to one percent of the total benefits paid.

As a Medicare contractor, we operate under very specific HCFA directives. HCFA audits various aspects of our operations anywhere from monthly to annually.

The Medicare Secondary Payer (MSP) Program is one of three safeguard programs established to ensure that Medicare Trust Fund dollars are appropriately spent. These safeguard programs produce over $3 billion in savings systemwide each year, more than Medicare's entire administrative budget in fiscal year 1990. The Medical Review and Provider Audit programs contribute to these savings, but my statement will specifically address MSP.

MEDICARE SECONDARY PAYER PROGRAM

The MSP Program was designed to ensure that Medicare payments are not made for services provided to beneficiaries who are entitled to benefits under certain other coverage. According to MSP regulations, Medicare is secondary payer for:

- claims involving Medicare beneficiaries age 65 or older who are entitled to benefits under employer group health plans (EHGP) based on their own employment or that of their spouse;

- claims during a period of up to 18 months involving beneficiaries entitled to Medicare solely on the basis of end stage renal disease and entitled to benefits under an EGHP:

- claims involving automobile medical, no-fault or any liability insurance;

- claims involving workman's compensation, black lung or Veteran's Administration benefits; and

- claims involving Medicare beneficiaries under age 65 who are disabled by Social Security definition and are entitled to benefits under a large group health plan (employers with 100 or more employees) based upon their employment or that of a family member.

Blue Cross and Blue Shield of Maryland's MSP Program has achieved a high level of success in its five years of operation. Our savings to the government for fiscal year 1990 totaled more than $45 million, well in excess of the target set by HCFA. In that year, we spent just over $1.4 million on MSP activities. This means that for every dollar we spent, we saved $32.

We achieve savings through two basic activities:

1. Obtaining other payer information prior to payment of a claim.

2. Using information gathered in the first process to identify prior erroneous payments and recover those dollars, commonly referred to as casework.

MSP PROCESS FOR HOSPITALS

The success of the Part A MSP Program is largely dependent on the institutional provider giving Medicare the appropriate payer information at the time a claim is submitted, which, in turn, depends on the provider obtaining other payer information from the beneficiary.

HCFA mandates that hospital admitting clerks (inpatient) or registration clerks (outpatient) ask the patient a specific sequence of questions designed to determine whether Medicare is, in fact, the primary payer. A sample of these questions is:

- Was the illness/injury due to a work-related accident/condition and covered by a workman's compensation plan or the Federal Black Lung Program?

- Are you currently employed? Is your spouse employed? Are you covered by an employer group health plan?

In general, we find that inpatient admitting clerks tend to ask a majority of these questions on a fairly consistent basis. Many hospitals in Maryland and the District of Columbia use automated inpatient admission systems that include MSP questions that must be answered before the admission can be completed. These automated admission systems help to assure that we get at least some of the information we need to determine the primary payer.

On the other hand, we have found frequent problems with hospital outpatient registration procedures. Hospitals generally offer a wide range of outpatient services throughout many areas of the facility. Consequently, registration procedures are often dictated by the individual outpatient departments rather than by a consistent, hospital-wide procedure.

This leads to a fundamental problem. If the registration clerk in an outpatient area does not ask all of the mandated questions, the billing department does not have sufficient information to determine just who the primary payer is. It is difficult for the billing department to obtain the missing information since by the time it is preparing the claim, the patient has left the hospital.

The result is that the billing department submits the claim to whomever appears to be primary which, in most cases, is Medicare. Hospitals can indicate that Medicare is primary through the use of a condition code which is placed on the claim. If that code appears on a claim, we must assume that the hospital made the determination by asking the mandated MSP questions. This, in fact, may not be the case.

MSP DATA GATHERING METHODS

Knowing that we might receive erroneous or no payment information from hospitals, we have in place several other methods of gathering MSP information.

First, HCFA has established an MSP auxiliary record for every beneficiary on the Common Working File (CWF), a beneficiary data base used by all contractors in a given HCFA region. If our MSP Unit learns that a particular beneficiary is covered under an employer group health plan, we enter this information

on our own data base and insert it into the CWF auxiliary record. Should Independence Blue Cross in Philadelphia, for example, receive a Medicare claim for the same beneficiary, the CWF auxiliary record will alert them that Medicare is not the primary payer for this claim.

On occasion, the information in the CWF auxiliary record is not complete or conflicts with information the provider is giving us on the claim. In that case we notify the hospital of the conflict and ask them to clarify the data. If they are unable to do so, we contact the beneficiary.

Another source of MSP information is the beneficiary himself. HCFA mandates that when we receive the first claim for a new Medicare beneficiary, we send him an MSP questionnaire which asks questions aimed at determining if another payer exists.

Often a beneficiary will contact us after receiving a Medicare Explanation of Benefits that tells him we paid a claim on his behalf. He will call to tell us we should not have paid that claim and provide us with the information we need on the other primary payer.

On the Part B side of the MSP Unit, we must rely on the CWF auxiliary record and the beneficiary, since Medicare regulations do not require physicians to question their patients concerning other potential payers.

HCFA will soon begin an Internal Revenue Service/Social Security Administration/HCFA data exchange. The purpose is to identify Medicare beneficiaries who appear to be employed and contact their employers to determine if the beneficiary carries EGHP coverage. This effort should strengthen identification and enforcement of MSP laws.

There is one other major source of MSP information utilized by both Part A and Part B -- the private side of Blue Cross and Blue Shield of Maryland. They voluntarily provide us with a quarterly report which lists all the claims they paid on behalf of Medicare beneficiaries. We use the data to capture savings (cost avoided claims) and to update our data base and the CWF auxiliary record. We also get copies of enrollment and reenrollment forms from our private side. This information is entered into our data base and the CWF auxiliary record and services to prevent future erroneous payments.

Once we identify a particular claim for which Medicare is not the primary payer, we also want to determine if any prior claims were paid erroneously. Our Part A Standard Claims Processing System automatically generates a list of prior paid claims whenever we deny a claim for MSP reasons. On the Part B side, we manually order a paid claims history. The list of prior paid claims is placed in a folder and becomes a "case." When we work the case, we will compare the EGHP policy and determine if these claims were paid erroneously. If they were, we will attempt to recover the erroneous Medicare payments.

PAYMENT RECOVERY

The process for recovering erroneous payments from hospitals and other Part A providers is relatively simple. We notify them in writing of the appropriate primary payer and give them 45 days to submit a claim to that payer. At the end of the 45 days, we retract our original payment from their weekly remittance.

Recovering a Part B payment is much more complicated. We first notify the primary payer, informing it of our erroneous payment and asking if it has also paid the claim(s) in question. If it has paid the claim(s), we attempt to recover our payment from the payee (provider or beneficiary). If the primary payer has not made a payment, we supply it with a copy of the claim(s) and request it to forward the amount owed.

Current HCFA policy mandates that we send a series of five demand letters over a span of 150 days. If we receive no

response from the payer or payee, we forward the case to HCFA who will negotiate a recovery on our behalf. Once they get the primary payer to agree to pay Medicare for the claim(s), the case is returned to us for actual recovery.

The actual process of recovering an erroneous payment is more complicated than the payer simply writing a check on demand. All payers request a copy of the claim(s) so that they can compare the actual services rendered to the EGHP contract. They, like Medicare, must be certain that the service rendered was medically necessary and covered under the terms of the contract. They also want to determine if a deductible or coinsurance is due. So, their adjudication of the claim(s) will extend recovery time.

Once the erroneous payment is recovered, the MSP Unit must process an adjustment to the original claim. This adjustment is needed to assure Medicare records accurately reflect benefit utilization and appropriately record the savings.

THE GAO REPORT

By the summer of 1988, we had created a backlog of cases. We had been extremely successful in identifying other payers, but were not sufficiently staffed to investigate the previously paid claims and recover those paid erroneously. In our fiscal year 1989 budget request, which was submitted during the summer of 1988, we notified HCFA of the backlog and requested an additional five caseworkers. We were given two. We continued to identify new cases and our backlog grew. In February 1989, the MSP Unit did an inventory of its cases and produced a handwritten list of cases noting the primary payer and the dollar value of the Part A and Part B claims within the cases. The list contained 3,059 cases totaling $8.8 million. In March of that same year, we shared this information with our private side and a committee was formed to address how to best "settle" these cases.

In July 1989, staff from the private side and MSP formed a coordination-of-benefits work group and began researching the Blue Cross and Blue Shield of Maryland cases. They confirmed EGHP effective dates by contacting the employer and then determined true liability for each of the claims in the case. By the end of September, the group had adjudicated 84 cases (695 claims) and Medicare had recovered $258,745.

The fiscal year 1990 budget mandated that we eliminate seven caseworkers, leaving us with 1.5 caseworkers. We were, thus, forced to greatly reduce casework activities.

The United States General Accounting Office (GAO) first visited us in April 1990. We furnished them with our handwritten inventory and they, in turn, produced a computerized listing which ranked the cases by payer and by dollar value. We also shared with the GAO budget documents and correspondence to and from the HCFA Regional Office concerning casework.

Since the April visit, we have resolved $3.5 million of the cases on the computerized list; we recovered $2.7 million in erroneous payments and found that Medicare was, in fact, primary for $.8 million. Most of this work occurred in September 1990 when HCFA notified us that money from the 1990 contingency fund was available to our MSP Unit during the month of September for erroneous payment recovery.

In our fiscal year 1991 budget request, we asked for an additional 5.5 caseworkers; the Notice of Budget Approval received from HCFA on January 10, 1991 gave us no additional staff. The MSP Part A Unit is continuing to work the cases on the GAO list, but they are not working any new cases. The MSP Part B Unit has ceased casework altogether.

BARRIERS TO SUCCESS

While still a young program, MSP has proven to be a valuable

payment safeguard. It is Blue Cross and Blue Shield of Maryland's firm belief that MSP could provide even more value to the Medicare Program were it not for certain barriers.

Since fiscal year 1989, our MSP Unit has been inadequately funded for the recovery of erroneous payments. As hospitals' admission/registration procedures and other sources of primary payer information have improved, we have become more successful in identifying erroneous payments. However, primarily due to a lack of funding, we are not able to devote sufficient resources to the recovery of these payments.

RECOMMENDATIONS FOR IMPROVING MSP

In order to improve the performance of MSP and save even more Medicare Trust Fund dollars, we offer the following recommendations:

SSA INFORMATION GATHERING

As effective as our current information gathering methods are, we still frequently find ourselves in a "pay and chase" situation. If the Social Security Administration were to require every new Medicare beneficiary to complete and submit a MSP questionnaire prior to issuance of a Medicare card, contractors would have valid primary payer information on file before the first claim was filed, minimizing erroneous payments.

FUNDING

We believe the federal government should provide increased, consistent funding for the MSP program. At the current 32:1 savings ratio, this is one of the best bargains in the Medicare program.

BUDGET SCOREKEEPING

We believe that the federal budget should explicitly count the savings that result from MSP operations as well as other Medicare contractor operations that prevent inappropriate payments. Congress established such a mechanism last year in OBRA 1990 where similar recoveries made by the Veterans Affairs Department from third party payers are now made available to finance a portion of the administrative costs of the Veterans Health Programs. Recoveries made by the Internal Revenue Service by auditing taxpayer records are also now considered hard savings for federal budget purposes.

The current budget process, which only counts the cost of administering the MSP Program and other Medicare payment safeguard operations, fails to provide incentives for either Congress or the Administration to invest in the sound management of Medicare. It also overstates Medicare's true, bottom-line administrative expenses by failing to recognize that properly funded contractor operations are highly cost-effective and continue to return to the budget far more than their appropriated cost.

SUMMARY

In closing, the Blue Cross and Blue Shield of Maryland MSP Unit has proved to be extremely successful in safeguarding the Medicare Trust Fund. With the aforementioned changes in the regulations and increased, consistent funding, it can be even more so.

I appreciate the opportunity to discuss these issues with you today. We look for your continued interest and support as we work together to improve the administration of the Medicare Program.

Thank you.
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Chairman PICKLE. Thank you, Ms. Jacoby.

Now, we will hear from Ms. Gagel, representing HCFA.

I am sure in your testimony you will make reference to the funding conditions expressed by Ms. Jacoby and the other recommendations.

We are pleased now to hear your testimony.

STATEMENT OF BARBARA GAGEL, DIRECTOR, BUREAU OF PROGRAM OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. GAGEL. Thank you, Mr. Chairman.

I am pleased to have the opportunity to discuss the Health Care Financing Administration's activities with you regarding Medicare secondary payer.

I have submitted a copy of my full testimony for the record.

What I would like to do is summarize it this morning. I believe you have been given a copy of the summarized statement as well.

Chairman PICKLE. Without objection, your entire statement will be included and all of the other witnesses' statements will be included.

Ms. GAGEL. Secretary Sullivan and HCFA Administrator Gail Wilensky are committed to seeing that the Medicare program does not pay for services for which private health insurers or other entities are liable.

The Medicare program by law cannot pay for services in certain situations when there is alternate insurance coverage. In these cases, the other insurance pays first. Medicare pays secondary for any covered services not paid for by a primary payer.

Now, HCFA has devoted significant effort and resources in the past several years to strengthen the enforcement of the Medicare secondary payer provisions, and as a result of that, has achieved nearly $10 billion in savings for the Medicare program. In fiscal year 1990 our secondary payer activities, despite the funding shortfalls that had been referred to here this morning, increased savings by over $300 million so that last year the savings to the Medicare program from MSP activities were $2.5 billion.

The Medicare secondary payer program is implemented through the contractors' claims payment process. HCFA provides exhaustive instructions to the contactors in the identification and processing of MSP cases. In addition, we provide contractors with an annual budget guidance which prioritizes contractors' tasks, including MSP, within the overall HCFA contractor budget.

In September 1990, secondary payer information was incorporated into the common working file. As a part of the common working file, detailed secondary payer information can be updated daily and is available on-line to every contractor in the country. Each claim then that is submitted to Medicare is automatically compared to this national data base before payment is approved or rejected.

Access to MSP information from the common working file has substantially increased our ability to identify potential MSP cases and to avoid making inappropriate primary payments.

We have also set MSP savings goals for contractors. These goals are individually determined, using State's specific data, actuarial

projections, statistics, and other information that is available to HCFA.

A contractor must achieve 95 percent of a targeted MSP goal in order to meet HCFA's performance standards. In 1990 and 1991, we added additional performance criteria to our performance evaluation program. We also now assess contractors' success in preventing inappropriate billings to the Medicare program and in submitting accurate and timely data to the common working file.

The purpose of these activities is really to avoid incorrect payments in the first place. When this fails, the contractor pays incorrectly and recovery of the misspent dollars is necessary.

Last fall we surveyed our contractors to determine the current backlog of these potential MSP recovery cases. As of October 1, 1990, there were 863,000 backlogged cases nationwide with a potential $218 million in savings.

In the last month, HCFA gave contractors $3.1 million, specifically for the reduction of that backlog. We have every intention of developing all backlogged MSP cases. We are also reviewing whether or not additional resources will be needed later in the fiscal year following identification by the data match of additional MSP claims.

On January 25, HCFA received the GAO's report identifying $8.8 million in MSP backlogs at Blue Cross and Blue Shield of Maryland. During the last month of fiscal year 1990, as Miss Jacoby indicated, we did allocate $100,000 to Maryland to work off that backlog. To date, they have resolved 3.2 million of those claims.

In the future, information from the common working file and the data match will give Maryland and all our other contractors tools that will facilitate MSP activities.

You asked, Mr. Chairman, in your opening remarks for information about the data match. I will be pleased to report to you on the status of the data match. Implementation of the MSP data match is well underway.

The data match between the IRS, the Social Security Administration, and HCFA will help us identify beneficiaries with health insurance from their employer or their spouse's employer. This latter category has been particularly difficult for us to detect and represents the largest category of undiscovered secondary payer savings.

Let me update you on the match activities. SSA had to provide the IRS with names and Social Security numbers of all Medicare beneficiaries for the years 1987 through 1989. IRS, in turn, provided SSA with a file of all Medicare beneficiaries and their spouses who had filed tax returns for those tax years of 1987 through 1989.

At the present time, the Social Security Administration is cross matching the IRS file against its master earnings file to determine whether a W–2 has been filed for the beneficiary or the beneficiary's spouse.

In March, as a result of the match that SSA is now doing, they will provide to HCFA the names and Social Security numbers of Medicare beneficiaries and their spouses and the name of that individual's employer. We, in turn, will contact that employer to determine whether or not that individual had health insurance cover-

age. This information will be put in the common working file, and all of our files will be updated automatically.

HCFA will also use the employer information to check the paid claims file for mistaken beneficiary Medicare payments to these same beneficiaries.

When mistaken payments are identified, the Medicare contractors will be instructed to recover the payments. We expect to begin this recovery action in early 1992. Funds are available in the budget to do that. We are spending approximately $8.9 million on the activity this year. We expect to spend $13.6 million on that next year.

Of the $13 million, $7.6 million of that will go to the contractors, specifically earmarked for recovery activities. We believe we have an effective secondary payer program, given the constraints that face us. Savings and recoveries of $2.5 billion in 1990 attest to that.

The data match will help us recover the large remaining portion of payments we cannot now identify. We will also continue to investigate alternative methods to identify secondary payer situations in a continuing effort to make the program more efficient.

I am confident that our secondary payer activities will continue to make a significant contribution to savings in the Medicare program, and I thank you for the opportunity to speak with you about them.

[The prepared statement follows:]

TESTIMONY OF BARBARA GAGEL, DIRECTOR
BUREAU OF OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION

Mr. Chairman and Members of the Subcommittee. I am pleased to have this opportunity to discuss the Health Care Financing Administration's (HCFA) activities regarding the Medicare secondary payer program.

Secretary Sullivan and HCFA Administrator Wilensky are committed to ensuring that the Medicare program does not pay for services for which private health insurers and other entities are liable. This is a goal that has been and will continue to be a priority for both the Department and HCFA.

Our current efforts will be enhanced by the effective implementation of the IRS/SSA/HCFA data match project authorized by OBRA 89 and extended through 1994 by OBRA 90. This data match will assist us in the identification of Medicare secondary payer cases, especially those resulting from spouses with health coverage through employment.

Background

The Medicare program, by law, cannot pay for services in certain situations when there is alternate insurance coverage. Medicare is secondary payer to an employer group health plan for certain elderly beneficiaries, for certain disabled beneficiaries, and for beneficiaries during the first 18 months of Medicare entitlement because of end-stage renal disease.

Medicare is also secondary payer to workmen's compensation and to automobile, liability, and no-fault insurance. This means that the other insurance or health plan pays first. Medicare will pay only for covered services not paid for by the other, primary payer.

HCFA has devoted significant effort and resources since 1984 to strengthen the enforcement of the secondary payer provisions, and has achieved nearly $10 billion in savings for the Medicare program. In FY 1990, our secondary payer activities increased by $300 million over FY 1989 savings to nearly $2.5 billion.

The Federal Role

HCFA has three primary responsibilities in administering the Medicare secondary payer program:

- To publish regulations, and issue policy and operational guidelines to implement the laws;
- To inform employers, insurers and providers of their responsibilities under the law. We must also inform beneficiaries of their rights under the law; and
- To identify situations where Medicare is the secondary payer and process claims accordingly.

Let me briefly describe our activities in each of these areas.

Administration of the Secondary Payer Program

Regulations - In 1989, we updated our secondary payer regulations by publishing a comprehensive rule incorporating major Medicare secondary payer requirements.

Informing and Educating - We believe that educating those parties with potential involvement in secondary payer situations is essential to assuring the success of the Medicare secondary payer program. Over the last three years, we have pursued an extensive educational campaign. We have mailed educational packages describing the MSP program to all State insurance commissioners,

to insurers, to employer groups, and to over 500,000 physicians and their staff nationwide. Radio and television public service announcements were also broadcast in the 31 largest television markets in 1988 and 1989. In addition over 5,200 presentations were made before groups representing beneficiaries, providers, physicians, employers, insurers, and third party administrators.

In September of 1990, HCFA sent out a pamphlet to more than 1 million employers explaining their responsibility under the MSP program. We also advised them of our data match project to identify MSP situations. At the same time, we worked with SSA to improve the pamphlet sent to first-time enrollees by including better reference information to MSP.

Identification of MSP Cases -- The Medicare secondary payer program is implemented through the contractor claims payment process. HCFA manual issuances provide exhaustive instructions to contractors in the identification and processing of MSP cases. In addition, we provide contractors with an annual budget guidance which prioritizes contractor tasks within the overall contractor budget. Contractors must develop a workplan that spells out how they will allocate their resources to meet budget priorities.

The budget process forces HCFA and the contractors to consider competing demands for funding. I would point out that the highest priority is assigned to claims processing - bills must be paid. Beyond that, we look at where we can get the best return for the limited dollars available. Within the MSP program, we have to balance funding demands for claim development, reducing backlogs, recovering payments, and all other MSP efforts.

Beneficiaries and providers are our main sources to identify and bill other primary payers of health care when Medicare is the secondary payer.

Beneficiaries provide information about potential primary insurance coverage when their first Medicare claim is filed. If the necessary information is not clearly provided on the claim form, contractors follow up with a questionnaire to the beneficiary asking about other insurance coverage, work status, and spousal work status. This information becomes a part of the our "common working file" data base to identify future claims where Medicare may be the secondary payer.

Providers also identify secondary payor cases. For example, hospitals and other providers are required, by their Medicare provider agreements and manuals, to ascertain primary health insurance information from beneficiaries at admission. Contractors audit hospitals to validate compliance with these requirements, and corrections must be made when deficiencies are identified.

Contractors also review all claims involving trauma which may have resulted from an automobile or work-related accident. They compare current claims to past claims to identify possible alternative coverage. Some contractors review their private insurance records to determine whether a Medicare beneficiary is covered under an employer group health plan.

In September 1990, secondary payor information was incorporated into the common working file, which is a national, unified system of beneficiary entitlement and utilization data obtained from claims. As part of the common working file, detailed secondary payer information can be updated daily and is available on-line to individual contractors. Each claim is automatically compared to the data base before payment is approved or rejected. Claims for primary payment are automatically rejected if the CWF has a

record of an MSP situation covering the dates of service of the claim.

Access to MSP information from the common working file has substantially increased our ability to identify potential MSP cases and to avoid making inappropriate primary payments. However, the availability of this better information also is contributing to the growth of our backlog of identified but unrecovered claims.

Monitoring Program Implementation and Savings

We are aware of the heightened interest in contractors' ability to ensure the accuracy of Medicare program payments in secondary payer situations. To improve the effectiveness of the secondary payer program, we have set savings goals for the contractors. These goals are individually determined using State-specific data, actuarial projections, statistics and other information available to HCFA. A contractor must achieve 95 percent of the targeted MSP goal to meet HCFA's performance standards.

Additionally, in FY 90 and 91 the MSP performance criterion was expanded beyond the savings goal to include an assessment of the contractors' success in preventing inappropriate billings to the Medicare program and in submitting timely and appropriate data to the Common Working File and its predecessor system.

Contractor Backlogs

Last Fall, we surveyed our contractors to determine the current backlog of potential retroactive MSP recoveries, including both undeveloped leads and identified but unrecovered mistaken payments. As of October 1, 1990, there were 863,000 backlogged cases nationwide with a potential $218 million in savings. Of the $218 million, $195 million represents identified but unrecovered mistaken primary payments. The remaining $23 million represents undeveloped leads, which will eventually be worked off as claims are processed. This includes undeveloped first claims, deferred history searches, and liability cases.

While a certain level of backlogged cases is not unusual, the situation has been exacerbated by necessary restraint in the contractors' current budgets.

To remedy this problem, we are directing significant resources toward contractor activities for developing these cases and seeking MSP recoveries. In the last month, contractors received $3.1 million specifically for reduction of the MSP backlog.

It's important to point out that we have not, to date, accrued any losses due to the expiration of time to recover the backlogs. The time limit for pursuing recovery will not be reached until January 1, 1992 for the oldest identified mistaken payments on record. HCFA has instructed its contractors to work off their oldest backlogs first in order to beat the time limitations.

We have every intention of developing all backlogged MSP cases. We believe that 75 to 80 percent of potential recoveries will turn out to be actual MSP savings. We are also reviewing whether additional resources will be needed later in the fiscal year following identification by the data match of additional MSP claims. Again, we will be forced to juggle competing contractor needs as we establish funding priorities.

On January 25 of this year, HCFA received a report from the General Accounting Office (GAO) identifying $8.8 million in MSP backlogs at Blue Cross and Blue Shield of Maryland (BC/BSMD). During the last quarter of FY 1990, BC/BSMD allocated $100,000 to

reduce these backlogs. We instructed them to concentrate their recovery efforts on those cases involving more than $5,000. To date, $3.2 million of claims have been resolved. HCFA fully anticipates resolution of all the remaining cases. We plan to continue to monitor closely and work with BC/BSMD in the coming months as they make progress on this backlog.

In the future, we do not anticipate that there will be a problem at Maryland with undeveloped MSP cases. Information from the common working file and the data match will give Maryland, and all our contractors, tools to facilitate MSP activities.

OBRA 1989 Secondary Payer Identification Provisions

Implementation of the MSP data match I mentioned is well underway. OBRA 89 legislation mandates a data match among the Internal Revenue Service (IRS), the Social Security Administration (SSA), and HCFA. OBRA 90 will provide additional savings through the extension of the data match program from September 1991 to September 1995.

In particular, the data match will help us identify beneficiaries with health coverage through their own employer's plan or their working spouse's employer group health plan. To date, this category of beneficiaries with primary health coverage through spouses has been difficult to detect. We believe that these beneficiaries represent the largest category of undiscovered secondary payer savings.

Let me update you on what we have done and the tasks yet to be accomplished in implementing the data match.

- The Computer Matching Agreement, required under the Computer Integrity Board of the Department of Treasury, was submitted to the Department of Health and Human Services' Board in September 1990.

- SSA has provided the IRS with the names and social security numbers of all Medicare beneficiaries for 1987 through 1989.

- The IRS has provided SSA with a file of all Medicare beneficiaries and their spouses who filed either separate or joint tax returns.

- SSA is cross-matching the IRS file against its Master Earnings File to determine whether a W-2 had been filed for the beneficiary or the beneficiary's spouse.

- In March of this year, SSA will provide HCFA with the names and social security numbers of Medicare beneficiaries and their spouses and, if a W-2 was filed, the name of the individual's employer.

- By the end of this March, employers will be getting a questionnaire from HCFA to determine the general availability of group health coverage for their employees and the size of their firm. An "800" phone number will be provided for employers with questions.

- This summer, Group Health Incorporated, our designated contractor for data match identification activities, will begin to contact employers to determine whether an individual had employer health coverage.
- The information developed from data match claims will be posted in the common working file. Additional development will not be required in order to process subsequent data match identifications of potential MSP cases.

- HCFA will use the employer information to check paid claims for mistaken Medicare payments. When mistaken payments are identified, the Medicare contractors will be instructed to recover payments.

We expect to begin processing recovery actions based on the data match project by September of this year and recoveries should begin early in FY 1992.

Data match funding for FYs 1991 and 1992 are $8.9 million and $13.6 million, respectively. These funds are based on our best estimates of workload and have been specifically set aside in the contractor budgets.

There may be a slight overlap in the data match claims and the current backlogs. Since recovery action must be initiated on claims currently backlogged before January 1, 1992, we are hoping to work off most of the current backlog before data match claims are processed.

FY 92 Proposals

For FY 1992, we are proposing to simplify and make uniform the criteria for employer group health plans subject to MSP. This proposal would make the employee size thresholds consistent for all MSP provisions. For the worked aged, disability, and ESRD provisions, Medicare would be secondary to employer group health plans with 20 or more employees. The proposal would also make disabled individuals covered by the MSP provisions consistent with the elderly provisions. Medicare would be secondary payor only by reason of current employment or the employment of a family member.

This type of program streamlining will result in a more equitable and consistently administered program.

Conclusion

We believe we have an effective secondary payer program, as the FY 90 $2.5 billion savings demonstrate. I can assure you, however, that we are not satisfied.

With the data match authority, we believe we will be able to improve our secondary payer performance substantially and recover a large portion of payments we cannot now identify. We will also continue to investigate alternative methods to improve the identification of possible secondary payer situations. I am confident that our secondary payer activities will continue to make a significant contribution in savings to the Medicare program.

I will be happy to answer any questions that you may have.

Chairman PICKLE. All right. Thank you for your testimony, and I thank all of you for your testimony.

In many cases, you have summarized your testimony. We will be reading again that summary along with your full statement.

We will also be submitting to each of you questions that we may not be able to cover today. We would like for you to respond as quick as you can because if we meet the April 15 deadline of trying to put together some kind of a solution, we will need your cooperation.

First, Ms. Gagel, let me ask you, Ms. Jacoby testified that their budget was cut at least two or three different times; that is, casework funding was reduced considerably. Is that a fact, or did they have sufficient case workers and why was this cut brought about?

Ms. GAGEL. The Maryland budget was cut because the national budget for MSP operations was cut in 1990 by about $8 million. And so, Maryland essentially took its fair share, if you will, of that reduction in 1991. And in 1991, there was another slight cut so that indeed we could fully fund the data match.

Chairman PICKLE. So you are saying that the cuts were made on a national basis, and Maryland just had to absorb their proportion and reduction in casework both?

Ms. GAGEL. Yes.

Chairman PICKLE. This was a special study, though, going on in Maryland, a pilot program more or less for the United States. Should they have been cut in the same proportion of all others?

Ms. GAGEL. I am not aware of the pilot activity, quite frankly, that you are talking about, Congressman. I don't think that the situation in Maryland, although the numbers may be slightly higher, is not radically different from any place else in the country.

Chairman PICKLE. All right.

Now let me ask Mr. Mangano and perhaps any others who made a statement, but Mr. Mangano had testified that some $900 million annually could be saved if we could make some of these corrections, if we could either periodically require the administrator to submit employer group health coverage data.

Now, you also stated that we should require Medicare beneficiaries to provide information about other primary insurance at the time they enrolled in Medicare programs at the very moment of their eligibility.

I think Ms. Jacoby made that recommendation. Mr. Mangano, how do you respond to the recommendations that the moment that individual, man or woman, applies for Medicare, that they should be furnished, be required to give this information about the spouse?

Mr. MANGANO. Well, I think any number of actions can have positive effects. I think that recommendation would be a help, but I should also point out that whenever a Medicare beneficiary makes that first claim and receives services under the program, a first claim is developed by the carriers. So even if we had a situation whereby the first time someone became eligible for it—it isn't necessarily that bad that that doesn't happen right now because the first claim is developed for every beneficiary.

Chairman PICKLE. Well, how do either Ms. Shikles or Ms. Jacoby, either one, or Ms. Gagel, what is your reaction to the suggestion that we ought to require beneficiaries at the very beginning, the

moment of the eligibility, to list with us the data with respect to the spouse, who is working and who is not working, what individuals have a plan, insurance plan?

Are you all in agreement that that would be a good thing?

Ms. GAGEL. We are in the process at HCFA of evaluating the feasibility of doing exactly that now, perhaps not at the time of enrollment, but prior to enrollment, when they make the decision about whether or not, for example, to take part B of Medicare.

The reason we need to look at the feasibility of that is that in the past when we did send out some questionnaires to beneficiaries we got a lot of incorrect and misleading data.

So we are looking now to see if we cannot perfect, if you will, a questionnaire that will give us accurate data. If we could do that, it would certainly be preferable to the other things that we are doing in the program now.

Chairman PICKLE. Well, in general then, this might be a good idea. We might be able to work that out.

Ms. GAGEL. We expect to finish that assessment in early April, so I will be able to provide it to you prior to your April 15 schedule.

Chairman PICKLE. When a person becomes eligible for Medicare, they are normally called on the telephone and notified that they will become 65, they will become eligible, do they want to enroll in part B, and that information is stated.

At the same time, by way of telephone, couldn't they also get from them such information about who is working, who is not working and what insurance plan they have? Could that not be done at the same time?

Ms. GAGEL. Yes, it could be. In fact, the enrollment package that they now receive from the Social Security Administration does include information about Medicare secondary payer, and asks some of those questions.

It is not very useful. It hasn't been successful for us.

Chairman PICKLE. Well, apparently it is not complete information by virtue of the fact you are conducting a data match now, the first time you are really trying to match the individuals with those who are working, and where they can be located.

You are doing an enormous job now. We hope that it will be a one-time sort of a program because that could be expensive and burdensome for the Government and for insurers and carriers both.

But we are required to do that now in order to get a handle on it. Up-front identification wouldn't be complete actually, because working habits will change or employees will change, but at least we will have pretty much the standard practice or employment practice of an individual.

So I think that is one suggestion that we ought to look into. Are you all generally in agreement on that?

Ms. SHIKLES. Yes. GAO hasn't specifically looked at that, but we think that makes a lot of sense.

Chairman PICKLE. I beg your pardon?

Ms. SHIKLES. We haven't specifically recommended that, but GAO thinks that makes a lot of sense.

Mr. SCHULZE. Mr. Chairman, may I ask a question along that line?

Chairman PICKLE. Yes.

Mr. SCHULZE. Ms. Gagel, I understand that HCFA had the pilot program in 1987, and it showed that it would save implementation, if you will, implementation would save some $80 million; but it was never implemented.

Ms. GAGEL. The pilot program that you are referring to is the beneficiary questionnaire?

Mr. SCHULZE. Yes.

Ms. GAGEL. The reason that was not implemented is because we did find that there were many problems with the quality of the data we received.

Mr. SCHULZE. So it was just shoved aside and said forget it?

Ms. GAGEL. No. It was evaluated, reevaluated again last year, and as I stated——

Mr. SCHULZE. In 1987.

Ms. GAGEL. That is right.

Mr. SCHULZE. This is 1991. Now, is that—you know, are you really telling me that it takes that long to get a definitive study or to reach a decision to make this thing work?

Ms. GAGEL. No. Quite frankly, in 1987 we decided it was not a good way, and that the pilot had indeed not been successful.

The MSP program——

Mr. SCHULZE. But you were aware there is a problem?

Ms. GAGEL. Yes, sir.

Mr. SCHULZE. So that is why we are here, because there is a problem. That you have taken this long to come up with little or nothing, at least at this point, it is just very discouraging.

Thank you, Mr. Chairman.

Chairman PICKLE. Well, thank you, Mr. Schulze.

Now, the Inspector General also recommended legislation establishing a voluntary disclosure and recovery program to permit insurers to identify instances of improper MSP payments, and, of course, to make restitution.

How would such a program actually work, Mr. Mangano?

Mr. MANGANO. Well, the insurers would be given a time period in which they would voluntarily disclose instances where they actually allowed Medicare to pay primary when in fact Medicare should have paid secondary.

What would happen during that time period is that we would not penalize them other than to pay the claims and the cost of the claims.

If they would not voluntarily disclose that they had made the payments secondarily instead of primarily, then they would be charged with treble damages, interest, and costs.

This could be carried out in any number of ways. It could be carried out, for example, under an ALJ system as opposed to going to the criminal courts.

Chairman PICKLE. Well, we might make that voluntary disclosure a requirement.

Mr. MANGANO. What we have recommended is that there be a legislative proposal that would open a period like that, and if insurers did not take advantage of it, then they be subject to treble damages.

Chairman PICKLE. Do any of you witnesses disagree with that general recommendation?

Ms. GAGEL. HCFA is working on the idea of drafting such legislation.

Chairman PICKLE. That is underway then. All right. That is encouraging.

Ms. GAGEL. OIG has the lead on it.

Chairman PICKLE. All right. We will look into that.

Now, I want to ask you one more question, and then I will yield to other members.

A lot of our problem is simply one that we don't know which spouse is working, which one, for how long, and we are trying to match up. But we don't have that information.

Now, it seems to me that a lot of our problems stem from the fact that in the case of hospitals, the hospitals simply are not following the law, or else they are not getting the information correctly.

Are the hospitals lax in trying to seek payments? Are they just quickly running to file with Medicare? Are they giving up because of slowness of the insurer, and they, therefore, think that it is easier to get payment with Medicare?

They desperately need the money because they have gone out of business, a lot of them, and partially because of such slow payment.

And is the fact of life such that they are really just going after Medicare because that is money that they can get quicker? Is that the reality of the case?

Mr. MANGANO. Well, Mr. Chairman, from our work, actually the hospitals are doing a better job than the private physicians are doing in this area.

Chairman PICKLE. Doing a better job?

Mr. MANGANO. From the studies that we have done overall, they are doing a better job than private physicians in terms of identifying primary payer sources, other than Medicare.

One of the recommendations we have made which seems to make a lot of sense is to require two very simple questions asked of the persons when they go to the hospital or to a private physician on the claim form, and that is, do you or your spouse have any coverage through an employer group help plan?

Chairman PICKLE. What part would they ask that?

Mr. MANGANO. It could be asked on the claim form when they are admitted to the hospital, or when they are in a private physicians office. That would take care of 90 percent of the problem on the basis of the study that we have done by identifying those sources right up front so that the hospital and the private physician——

Chairman PICKLE. And you are saying that hospitals do not require that or physicians do not require that?

Mr. MANGANO. The hospitals require certain information. The hospitals and physicians are required to ask beneficiaries if there is another primary insurance that should be paying first.

However, in the case of physicians' offices, there is not a requirement when the physician sends the bill to the Medicare program.

Chairman PICKLE. All right.

Should we require that of physicians?

Mr. MANGANO. Our recommendation is that it be required as part of the claim form.

Chairman PICKLE. Does anybody disagree of requiring physicians to give that information? Does anybody disagree generally to that approach?

Good. All right.

Anybody else have any comment? That is good.

Now I will yield to Mr. Schulze for any questions.

Mr. SCHULZE. Thank you, Mr. Chairman, for yielding. I will be very brief.

I think that the chairman's questions sort of express my frustration. It seems to me when we have these hearings it becomes obvious what has to be done, and yet we sit around and don't do them until somebody puts their fist down and says, we have to do these things.

All I hear is additional resources are needed, additional resources. Now somebody has got to tell me why there cannot be a button on the computer that when a secondary payer pops up to just push a button and send them a letter. And I don't know why that takes millions and millions of dollars to do that.

I cannot understand that. It should be a relatively simple, ordinary, normal process. If this was a profit-making business, that would be there.

And I am very concerned that the data match hasn't been done before. If the contractors don't want to do this and cannot do it, we ought to get new contractors.

I just cannot understand why HCFA overseeing this has not put more pressure on these people to do it. And as I say, I am not going to ask a lot of questions. I know the chairman has instructed the staff to sit down with you people, come up with your recommendations, and then come up with some tough legislation.

It seems to me that that is what we are going to do and there is no use going into who shot John in the meantime.

I am just expressing my frustration, I think, at individuals out in the public sector who look at this as another typical way that we are taking the taxpayer's money and not sheparding it in a wise way.

And it is very frustrating to see this happen. I don't like it, and I am willing to vote for very strong legislation to correct it. It could have been corrected from within. It obviously was not, and I am sorry that it has not been.

And I yield the balance of my time.

Mr. ANTHONY [presiding]. The gentleman yields back the balance of his time.

Would any of the witnesses like to respond to Mr. Schulze's frustration? He does this every time. He seems to be a very frustrated individual.

Mr. Mangano, in your testimony you said that there was a 20-percent error rate in payment. Would that mean, or are you saying that in your investigation and in your studies of the cases that you have seen that you are making a projection that of all of the Medicare payments that there is a 20-percent error rate?

Mr. MANGANO. I believe the 20 percent that I had in the testimony referred to a problem that exists when a private insurer is also a contractor, and they are not matching their private insurance files against Medicare.

Therefore, about 20 percent of the money that is accountable for mispayments is because the primary insurer is also the contractor, not matching those files against one another.

Mr. ANTHONY. Of the ones you studied, you would say that that is a 20-percent rate?

Mr. MANGANO. Twenty percent of the dollars lost.

Mr. ANTHONY. What was the Maryland experience?

Mr. MANGANO. I would have to refer——

Mr. ANTHONY. Closer to 50 percent, wasn't it?

Mr. DAVIS. That is correct.

Mr. ANTHONY. I take it from your testimony your recommendation is then that there be a match between Medicare payment and the contractors private insurance carriers files?

Mr. MANGANO. That is correct. At the current time——

Mr. ANTHONY. And then we would save 20 percent overall, and in Maryland we would save 50 percent?

Mr. MANGANO. Nationally we would save 20 percent.

Mr. ANTHONY. That seems to be a very rational request. Who opposes that?

Mr. MANGANO. Right now the Congress passed legislation a year or two ago that prohibited that.

Mr. ANTHONY. That is the 1989 OBRA law?

Mr. MANGANO. I believe it was.

Mr. ANTHONY. Are you recommending to this committee that that be overturned?

Mr. MANGANO. Yes.

Mr. ANTHONY. And you are saying that if we overturn it, we could look forward to a 20-percent reduced error rate among those cases where the carrier is also—or the contractor is also a carrier of a second party payer?

Mr. MANGANO. That is correct. Nationally you would recover 20 percent.

Mr. ANTHONY. All right.

To Mr. Simon, you stated that in your opinion, after having studied the Provident Insurance Co. scam, you thought that it was purposeful, and in your own opinion, you have made a judgment that the purposefulness had gone beyond the civil bounds, and it had encroached upon criminality.

And based upon that judgment, you referred the case to Justice. Why did Justice not agree with you that the purposeful nature of ripping off the Federal Government was criminal and reduced it back to civil?

Mr. SIMON. Well, the Justice Department, as I said in two judicial districts in Tennessee and one in Georgia, felt that we hadn't met the burden of proof, that we had not proven that the level of willfulness rose to criminality in that case.

Mr. ANTHONY. In other words, they didn't think they could get it past a jury on reasonable doubt?

Mr. SIMON. That is exactly right.

Mr. ANTHONY. Did they feel like they could get it to the jury, past a directed verdict by the judge and let the jury determine whether or not there was reasonable doubt, or were they just afraid to go to court with it?

Mr. SIMON. I think they felt that there was a reasonable doubt problem in that.

Mr. ANTHONY. After having conferred with them, did they convince you of that?

Mr. SIMON. I abide by their decision, Mr. Anthony.

Mr. ANTHONY. We all abide by their decision. I don't know anything about the case, and I abide by their decision.

I mean, you are eminently qualified to make a judgment. Do you agree or disagree with the prosecutors in those two judicial districts? Do you think they blew it or do you think they could have gone to court with it and won the case?

Mr. SIMON. We recommended that they prosecute, Mr. Anthony.

Mr. ANTHONY. And you haven't changed your opinion?

Mr. SIMON. I have not. The civil suit is still ongoing. It has not come to closure yet.

Mr. ANTHONY. Have there been any negotiations for settlement?

Mr. SIMON. There have been, but since it is an ongoing civil suit between the Justice Department and Provident, I really should not discuss that.

Mr. ANTHONY. Has a case been actually filed? Has a civil action been actually filed?

Mr. SIMON. Yes, there has.

Mr. ANTHONY. Has there been an answer filed in that case? Has Provident admitted or denied?

Mr. SIMON. They denied. Well, they denied the extent of liability that the Government asserts, of course.

Mr. ANTHONY. Do you feel like the civil action has been pursued vigorously, or is it kind of lying around?

Mr. SIMON. It is being pursued vigorously.

Mr. ANTHONY. Do you think it is likely to be concluded this year?

Mr. SIMON. I do not. I think 12 months from now would be an optimistic projection.

Mr. ANTHONY. We should write them a letter and tell them that we are taking a close look at it.

Mr. SIMON. I could do that, sure.

Mr. ANTHONY. Ms. Shikles, you state that there has been an increase in the mistaken payments since October of 1989. What do you base that on?

Ms. SHIKLES. Our visits to different carriers have identified a lot of system problems. Carriers have basically stopped recovering mistaken payments. There have been some other payment control errors. So we think that the number of mistaken payments is growing.

Terry, do you want to add anything?

Mr. DAVIS. Yes. That pretty well summarizes it. I think the one control that Mrs. Shikles was talking about occurred because of the budget cuts. HCFA had to make some amends and lower the number of cases that otherwise were being reviewed.

In other words, as we state in our testimony, prior to the budget cuts, contractors were reviewing cases of $50 or more for other insurance coverage.

Because of the workload and the pressure of the budget cuts, the threshold was raised to $250.

Mr. ANTHONY. Mr. Davis, Ms. Shikles, based on your study, do you think there is a direct correlation between the increased mistaken payments and the increased loss to the Federal Government and the decrease in the funding of this program through the budget cuts?

Ms. SHIKLES. Yes, we do.

Mr. ANTHONY. That is what you are telling this subcommittee, that there is a direct correlation.

Ms. SHIKLES. Yes.

Mr. ANTHONY. If we want to reduce the error rate, if we want to have more case workers out there and recover more money and have an effectively run program, we ought to give HCFA more money so they can give the carriers more money to do a better job of oversight?

Ms. SHIKLES. We think two things. We think more money is needed, but we also found different situations at each carrier. Some have better systems than others. Some are still using handwritten ledgers to recover cases.

Mr. ANTHONY. Where did you find the best systems? Where did you find the worst systems?

Mr. DAVIS. I think the example that Ms. Shikles is referring to is the situation in Maryland.

Mr. ANTHONY. Is that a good or a bad system?

Mr. DAVIS. Their system was good at identifying mistaken payments, but they weren't good at keeping tack.

Mr. ANTHONY. They would identify and then lose them?

Mr. DAVIS. Yes. Keeping them in file cabinets on handwritten sheets doesn't appear to be very efficient.

Ms. SHIKLES. They put them in folders and kept handwritten ledgers. It is not an efficient recovery process when you have computers.

Mr. ANTHONY. Not a very modern technology, considering that most operations are computerized nowadays.

Do you think they would be better attuned to collecting the approximately $8 million if they were better organized and more modern in their office management skills?

Ms. SHIKLES. Well, I think system upgrades for some of the carriers would certainly help the situation. The reason they haven't done that is because the total contractor budget hasn't kept pace with the workload.

Mr. ANTHONY. When they are hired as a contractor, then all of the payments to monitor the systems and upgrade the systems and to carry through with what the systems discover would be the responsibility of the contracting party, that would be HCFA?

In other words, if HCFA does not give the contractor adequate means, then HCFA is really the guilty party?

Mr. DAVIS. I think the answer to your question is HCFA funds the contractor operations, reimburses them for their costs, including systems upgrades, and that sort of thing.

Mr. ANTHONY. So if HCFA squeezes what they know to be an effective program, then they know that they are going to get an ineffective program because of the squeezes that they are doing?

Mr. DAVIS. I think that is fair to say.

Mr. ANTHONY. HCFA has a role that they can play in the Congress, so I am sure she will have an opportunity to talk about this in a minute.

I was disturbed to hear that you say that the carrier for California—and I understand that to be Occidental?

Ms. SHIKLES. There are two carriers.

Mr. ANTHONY. Aetna and Occidental?

Ms. SHIKLES. Blue Shield and Occidental.

Mr. ANTHONY. Which one lost the 50,000 data conversion?

Ms. SHIKLES. Blue Shield.

Mr. ANTHONY. And they have been notified about that? They are aware of it?

Ms. SHIKLES. Yes.

Mr. ANTHONY. Have they made any attempt to correct it?

Ms. SHIKLES. We learned about it when we were looking at their activities. We went to draw a sample to try to come up with a list of cases and learned that they had deleted information on about 50,000 beneficiaries.

We have been working with them.

Mr. DAVIS. They are trying to correct the problem that they experienced during that conversion. However, we, as part of our sample, we have seen cases that were paid outside that 2-week period that indicate that they have not yet corrected that problem.

So we are continuing to work with them.

Mr. ANTHONY. Will you continue to work with them on that?

Mr. DAVIS. Yes.

Mr. ANTHONY. I mean I must admit that I might have to jump over a couple of chairs and get in Mr. Shulze's chair, when I hear that there is a problem that has been made known to a carrier and they take a callus or cavalier attitude: "I am not trying to do anything about it," and yet you have identified some followup red flags.

So there is not much we can do today about that, other than to encourage you to encourage a carrier to try to retrieve those 50,000 and follow up on them.

You had something you wanted to say?

Mr. DAVIS. Yes, sir.

They have informed us that they have corrected the 50,000 in question. We have not verified that, but we have seen other cases perhaps suffered from the same or different problems. We are continuing to work with them.

Mr. ANTHONY. Are you talking about the claims over 40,000, that according to your testimony exhibited no effort to recover, or are you talking about other problems?

Mr. DAVIS. Other problems.

Mr. ANTHONY. What other problems?

Mr. DAVIS. We found cases that were supposedly not part of the 50,000, where the insurance information was also not present.

So we are continuing to work with them on these cases.

Mr. ANTHONY. Well, would you just continue to update our subcommittee so that we can make sure the record remains current?

I don't want the record to remain incorrect as it concerns that carrier, if they are doing something positive. But if they are not doing something positive, I certainly want the record to reflect it, also.

I just want the record to be complete and equitable to both parties, so if you could keep us posted on that.

Ms. SHIKLES. We will do that.

Mr. ANTHONY. Ms. Jacoby, you indicated in your testimony that there had been a $45 million savings in 1990 or a 32-to-1 cost benefit ratio?

Ms. JACOBY. That is correct.

Mr. ANTHONY. I have a couple of broad questions for you. I think they have kind of picked your operation apart, and you have given us your response in your oral testimony.

But if wrongful payment is a problem, and if information, data gathering is essential, why does it not make common sense to require evidence of additional group insurance?

It seems that group insurance has been identified as one of the largest areas where the mistaken payments occur.

Ms. JACOBY. I am not sure what you are getting at; mandatory disclosure of this information from insurers?

Mr. ANTHONY. Exactly. In other words, if we know that we are making wrongful payments and if we know that information gathering is essential, and if we know that it has come primarily from group insurance, why doesn't it make sense for us to require evidence of additional insurance?

Ms. JACOBY. It does to a degree, except I see a few problems. Number 1, what we are currently doing with our private side still brings us information after we have paid a claim.

Mr. ANTHONY. I know, but why don't we get it beforehand?

Ms. JACOBY. Well, that is fine, and that is why we suggested the SSA enrollment procedure.

Mr. ANTHONY. Let's just take Maryland, for instance. You are Blue Cross Blue Shield, right?

Ms. JACOBY. Yes.

Mr. ANTHONY. With Maryland?

Ms. JACOBY. Yes, sir.

Mr. ANTHONY. You do two things. You contract with HCFA to manage the MSP program.

Ms. JACOBY. Yes.

Mr. ANTHONY. You also have another component of your company that actually sells group insurance.

Ms. JACOBY. True.

Mr. ANTHONY. As the carrier, why could you not ask the other side of your company to provide you access to group insurance data so that you could match them, so that you could eliminate errors?

Do you not want to do that?

Ms. JACOBY. We do want to do it, and we do do it. That is part of the reason we have the $9.8 million backlog in cases.

Mr. ANTHONY. It is my understanding that the 1989 law prohibited you from doing that.

Ms. JACOBY. It did not prohibit us from doing it. It eliminated an attempt to make it mandatory for all contractors to do a data exchange with their private——

Mr. ANTHONY. You do it on a voluntary basis?

Ms. JACOBY. Yes, and it is not really a data exchange. They simply produce a report.

Mr. ANTHONY. Mr. Mangano said that if there was this exchange of information nationwide, you get a 20 percent savings.

In Maryland, how come you wouldn't have discovered the 50 percent error rate because Blue Cross Blue Shield was responsible for 50 percent of that problem?

Ms. JACOBY. We did discover——

Mr. ANTHONY. Well, have you recovered 50 percent of the total loss or the total—when I say "loss," total mistaken payments?

Ms. JACOBY. No, we have not—50 percent of our total debt is $8.8 million for all cases in our inventory.

Mr. ANTHONY. And Blue Cross of Maryland owes half of that.

Ms. JACOBY. Yes, they do.

Mr. ANTHONY. They have paid it.

Ms. JACOBY. No. They are going to pay it when Medicare sends them notification that we suspect they're primary payer sends them claims copies. After they do what we do, look and make sure that that service is covered under the EGHP contract, making sure that the service is medically necessary, making sure there is no deductible due.

At that point, they will send us a check.

Mr. ANTHONY. Would you support this committee if we attempt to override the 1989 law so that we make it mandatory with all carriers?

Ms. JACOBY. I would, from my own personal viewpoint now, I would if it extended to all commercial insurers and TPAs.

Mr. ANTHONY. I am just saying repeal it and require it. Would your company executives support that?

Ms. JACOBY. Let me clarify what I just said. I would support it if I, as Blue Cross Blue Shield, also received a quarterly report from Aetna, or from——

Mr. ANTHONY. I understand, and that is what the law would do.

Ms. JACOBY. I would support it with some reservations. We will have data, but we will have it after the fact. We will still be in a pay and chase situation. We will be inundated with paperwork from all these different insurers, TPAs, payers.

Mr. ANTHONY. Why would other insurance companies not support that? Do they support overpayment and mismanagement?

Ms. JACOBY. No, I don't think they do.

Mr. ANTHONY. Or are they just saying I don't want to have any more mandatory laws put on me and that is going to create internal burdens?

Ms. JACOBY. That could be it, and it is my understanding too, that the law that was considered a few years ago only addressed contractors and their private sides, not contractors and other commercial insurers or TPAs.

Mr. ANTHONY. Well, it appears to me that maybe the time has come for us to take a new look at that. Maybe in 1989 it sounded like a good deal, but based on GAO and the IG and other evidence,

it appears to me that maybe now is the time to require that across the board.

So if you want to inquire of your company executives and have them put anything in the record about it, I would love to hear from them in terms of what problems that would create on the private sector side.

Mr. Chairman, I just have one final series of questions for Ms. Gagel. And again, it is a broad question based on cumulative testimony that has been given.

You, in your own testimony, closed out by saying that the MSP was an effective program considering the constraints facing us. And I assume you meant us, HCFA. The constraints that you refer to are those budgetary constraints or other constraints?

Ms. GAGEL. No. The constraints, I think, are primarily the fact that we don't have—that we have to go out and play detective, quite frankly, to find out who has other—which Medicare beneficiaries have other insurance.

If, indeed, there was a reporting scheme so that indeed we were informed, as many here on the panel have suggested, that is clearly——

Mr. ANTHONY. So if we could help you solve the chase and pay, then some of the constraints would be lifted, error rates would go down, mismanagement would go down, the Federal Government would be more cost-effective in managing this program.

It seems to me that we ought to work with you to ensure that.

Let me just summarize some things. Do you agree with the 32-to-1 cost ratio return? That has been testified to?

Ms. GAGEL. Nationally last year it was 35 to 1.

Mr. ANTHONY. Even higher than the 32, 35 to 1.

Did Maryland ask you for five additional case workers?

Ms. GAGEL. I believe they did, yes.

Mr. ANTHONY. You gave them two?

Ms. GAGEL. Two was in their regular budget, yes.

Chairman PICKLE. One point five.

Mr. ANTHONY. Well, I kind of rounded up. In their 1991 budget they requested five after they had been made aware of this enormous problem, and they were trying to work on it.

And HCFA's response was zero?

Ms. GAGEL. That is, in terms of an increase, yes.

Mr. ANTHONY. My broad question to you is this: Why does the Administration not want to curb fraud, mismanagement, and wrongful payments, if you know it is cost-effective, and if you know that there is an ongoing problem, and if they have requested more case workers and you have consistently refused them the needed and necessary tools to solve their problem?

Ms. GAGEL. Well, I would certainly not agree that the Administration is in any way in favor of fraud, abuse, or mismanagement.

Mr. ANTHONY. Would you agree that there is room for disagreement?

Ms. GAGEL. There may be. I think it is very much a question of priorities. There is clearly not enough money to do everything that needs to be done in MSP. There hasn't been since the program began. We have a 38——

Mr. ANTHONY. Do you know of any other programs in the Medicare area that is more cost-effective than 35 to 1?

I assume by priorities that means that is where you are spending your money.

Ms. GAGEL. There is none. But there are numerous activities in the contractor budget such as paying claims on time.

Mr. ANTHONY. I understand that you have enormous monetary problems and are going to have additional area problems because your request that has been submitted this year asks for an additional $5 billion worth of cuts in Medicare.

So I guess, Mr. Chairman, she will get that 1.5 case worker. I am not sure how we are going—that means we are going to give you somebody under age, or somebody that is not capable, or if that means that we are going to play the biblical sense and try to divide the baby.

But I must tell you from all of the evidence that has come out here, it appears to me that HCFA has some of its priorities misplaced, and I would encourage you to keep working internally within your organization to try to fine tune this program.

It seems to be one where all parties working together can come to a meeting of the minds where we can all be very proud of this particular program, albeit it is a fairly small program when you look at the total cost.

But it would be nice to be able to go home and brag about the Government doing something good for the constituents, and I think all of you have a golden opportunity here.

The purpose of this hearing is to try to give you the tools that you need to do a good job, and I encourage you to keep trying to do that.

Thank you, Mr. Chairman.

Chairman PICKLE. Well, I thank you, Mr. Anthony.

From the testimony that each of you have given, I think there is a general agreement that there is a problem here, that something should and must be done about it, and that steps are underway now to try to correct this.

I think it is also fair to observe that HCFA has moved very slowly on this because of the complexity of it, because of lack of funding, and for any other reasons.

But I want to ask you, Ms. Gagel, and others of you, that this committee puts a priority on this issue. It just simply is not defendable to say that we are paying out money to other insurers when Medicare is the second payer, and something is going to have to be changed with this thing and changed with some priority. I will just make that observation.

Mr. Sundquist.

Mr. SUNDQUIST. Thank you, Mr. Chairman.

First of all, I want to compliment GAO. I think they have done a wonderful job of revealing the problem and analyzing the problem.

Ms. Gagel, are you a careerist with HCFA?

Ms. GAGEL. Yes, I am.

Mr. SUNDQUIST. How long have you been with HCFA?

Ms. GAGEL. Ten years.

Mr. SUNDQUIST. So you are not a political appointment; you are a careerist?

Ms. GAGEL. That is correct.

Mr. SUNDQUIST. On the first page of your testimony, you say the Medicare program by law cannot pay for services in certain situations where there is alternative insurance coverage.

And, in other words, you are mandated by law not to pay out for services that are wrong; right?

Ms. GAGEL. That is correct.

Mr. SUNDQUIST. What about on page 1 of the GAO summary, it said because of MSP funding cutbacks, carriers have done little to collect mistaken benefits or payments from other insurers since October 1. How do you square your mandate by law with that statement that you haven't been—that the carriers you are supervising haven't been doing it?

Ms. GAGEL. Because the carriers have not done it does not mean that the carriers will not do it, nor that money will be made available. Because they have not done it, it does not mean that the money has been lost to the Medicare program. We still have the opportunity to recoup those funds.

Mr. SUNDQUIST. How long do you have?

Ms. GAGEL. For recoveries for cases that were discovered after, I think, September of 1989, we have until January of 1992.

Mr. SUNDQUIST. So you got about 10 months?

Ms. GAGEL. We have a number of cases that need to be resolved this year, yes.

Mr. SUNDQUIST. So you expect that you are going to go back and all the information will be there to collect all that past mispayment; right?

Ms. GAGEL. That is exactly what we hope to be able to do, yes.

Mr. SUNDQUIST. I hope that the record will note that so we can come back next year and see how successful you were.

Let me ask another question. Let me ask another question before I get to that, even.

We pay interest, the Government pays interest if the payments aren't made on time; is that correct?

Ms. GAGEL. That is correct.

Mr. SUNDQUIST. So if we are past what, 17 days with the physicians, is that right, 24 days, with hospitals?

Ms. GAGEL. Yes, that is correct.

Mr. SUNDQUIST. How are you going about getting that interest then? In some cases, we have paid that out, have we not?

Ms. GAGEL. I don't know. I would have to provide the answer to that for the record.

The recoupment process would be exactly the same as the payment process. You essentially work it in reverse. I think if we incorrectly paid interest, we would get the interest back.

[Additional information follows:]

Providers are obligated to pay interest that Medicare mistakenly paid as primary payer.

Mr. SUNDQUIST. What if we made a rule that said we are not going to pay out within 17 days unless the information is furnished. Is that the kind of thing that makes sense? What if we required——

Ms. GAGEL. Yes.

Mr. SUNDQUIST. Should we require the physician to do that? Should we require the hospitals to do that?

Ms. GAGEL. Require information about whether or not there is other insurance?

Mr. SUNDQUIST. That is correct.

Ms. GAGEL. That is certainly one option.

Mr. SUNDQUIST. Is that one that you would support, makes sense?

Ms. GAGEL. It is problematic in that hospitals and physicians really feel that it is essentially the Government's responsibility rather than theirs to provide this information. It would involve a vast, I think, training program for us.

We have made any number of efforts in the past several years, ever since the MSP program began, to work with hospitals.

In fact, hospitals are given a fairly extensive set of instructions on how to ask the series of questions that one needs to ask to determine whether or not Medicare is primary or secondary.

Two years ago, we did a massive mailing to all physicians and their offices in this country informing them again of the Medicare secondary payer program and asking them to ask their patients whether or not they have insurance in addition to Medicare.

We think it is a major assist to us if they do that.

Mr. SUNDQUIST. Let me ask you this: In the private sector, don't they ask for this information?

Ms. GAGEL. Certainly. Certainly.

Mr. SUNDQUIST. I am looking at one form where they ask if the subscriber is married, is the spouse employed; if yes, give the name of the spouse's employer; and is the patient actively employed, if yes, name of employer.

Now, I am looking at your form from your agency, and you don't ask that. Now, that doesn't seem too complicated to me, and it seems to me that that would be at least a minor step toward solving the problem, wouldn't it?

Ms. GAGEL. Those are the kinds of questions we would have to ask the beneficiary at the time of enrollment.

I don't think that we could expect the physician to ask that in the billing office. He is going to simply have to ask whether or not someone has other insurance and if so, what type of insurance that is.

We do ask them to do that now and to place that information on the billing form. There is space for it on the billing form, and indeed, we revised the billing form early this year; and it will go into production before the year is over. This will significantly enhance our ability to get that kind of information.

Mr. SUNDQUIST. Why would it be on the private sector form but not on HCFA's form?

Ms. GAGEL. I am sorry, I don't know what private sector form you are referring to.

Mr. SUNDQUIST. BACE health benefits claim forms. I assume they are not the only ones that do that.

Would GAO care to comment on this?

Ms. SHIKLES. It sounds to us that it makes sense.

Mr. DAVIS. I think your point is well taken. When I go to a physician, I have to furnish that same information. As you are pointing

out, it is done in the private sector. It doesn't seem like that radical of an idea.

Mr. SUNDQUIST. It doesn't seem like it to me.

Now, I would like to ask the HHS IG folks a couple of questions. Are hospitals required to screen patients for other health coverage?

Mr. MANGANO. Yes, they are.

Mr. SUNDQUIST. What is the penalty for not doing so?

Mr. MANGANO. I am not sure. I don't know.

Mr. SUNDQUIST. Are hospitals required to keep copies of beneficiary questionnaires on file?

Mr. MANGANO. They will send in to Medicare what they call no pay claims, which means the following: If a Medicare beneficiary receives treatment in the hospital, and the hospital determines that that person has coverage through another insurance company, they will send a copy of the bill to Medicare so that Medicare knows that that person does have a primary insurer.

That is kept in their files so that the next time they see that beneficiary mentioned on a claim, they will know that there is another primary payer.

Mr. SUNDQUIST. So they keep that on file, this form right here; correct?

Mr. MANGANO. I believe they do.

Mr. SUNDQUIST. The form for identifying other primary payers during the admission process.

What is the penalty for not doing so?

Mr. MANGANO. I don't know.

Mr. SUNDQUIST. Would you answer both of those questions for the record at a later point?

Mr. MANGANO. Yes, sir.

[Additional information follows:]

1. Are hospitals required to screen patients for other health coverage? What is the penalty for not doing so?

The Health Care Financing Administration (HCFA) has issued regulations which require hospitals to ask a series of health coverage questions upon a patient's admission to a hospital. If HCFA determines that a hospital is not complying with these regulations, it can determine that the hospital is out of compliance with its conditions of participation and commence termination action against the hospital. As a practical matter it is extremely unlikely that a termination action would be taken based solely on the hospital's failure to request appropriate health coverage information.

HCFA may also assess overpayments against hospitals and physicians in situations in which HCFA is unable to collect MSP funds due from another insurer because that provider failed to obtain appropriate MSP information from the patient.

Based on the limited penalty authorities under current law, we believe it would be appropriate to include in any MSP bill an authority which would allow HCFA to impose a monetary penalty against hospitals and doctors who fail to collect appropriate MSP information from patients.

2. Are hospitals required to keep copies of beneficiary questionnaires on file? What is the penalty for not doing so?

Hospitals are required to maintain a copy of the beneficiary questionnaire. Under current regulations, HCFA may assess an overpayment against a hospital in situations in which HCFA is unable to recover MSP funds from another insurer because the hospital failed to maintain appropriate MSP information. Again, we feel that it may be appropriate to give HCFA the authority to impose monetary penalties for certain egregious violations of this type.

Mr. SUNDQUIST. You recommend a 1-year amnesty for insurers to come in and disclose erroneous payments. What are the penalties now for keeping the erroneous payments?

Mr. MANGANO. At the current time, that is the subject of what some of the lawsuits that we have talked about in the testimony are all about. What right now is the penalty is that they, when identified, must pay those; and that to my knowledge is the extent of the penalty at the current time.

Mr. SUNDQUIST. So what should they be, penalties?

Mr. MANGANO. What we are recommending under that voluntary disclosure and recovery act is that they be penalized if they do not pay within the time period that the law would allow. They would pay triple damages plus interest and costs.

Mr. SUNDQUIST. And maybe you said this earlier, but have you worked up any proposed legislation?

Mr. MANGANO. Yes. We have been working with HCFA on that, and it is currently, I believe, right now in the Office of Management and Budget for review.

Mr. SUNDQUIST. Thank you. I would like to ask Ms. Jacoby a question. My impression is that once contractors and Blue Cross, perhaps, once there was a reduction in funding, you virtually stopped trying to go after the other older payments.

Ms. JACOBY. We greatly reduced our recovery efforts. This was in response to the fiscal year 1990 budget cut.

Mr. SUNDQUIST. Did you reduce it proportionate to the cutbacks or more?

Ms. JACOBY. I would say proportionate. We have continued to work the backlog. Right now we are directing all of our activities to the GAO list.

But in terms of the part B side, we lost all our case workers, so we stopped all case work.

Mr. SUNDQUIST. Now, on page 3 of GAO's testimony, it says we have identified situations where for various reasons carriers have paid claims totaling millions of dollars, after learning the beneficiaries had primary coverage.

Are you all guilty of that?

Ms. JACOBY. I don't believe so. When we find out there is another primary payer, even though we may not go out and recover previous payments, we do enter this new information into our data base and into the CWF auxiliary records so that others are prevented.

Mr. SUNDQUIST. Would GAO care to comment on that statement?

Mr. DAVIS. I believe you are referring to the statement in our testimony.

Mr. SUNDQUIST. Yes, on page 3.

Mr. DAVIS. Again, we are referring to a couple of different situations. In Florida, because of their system problem, even after a beneficiary or another insurer informed Medicare that other insurance was present, carrier officials told us that their system didn't have the capability to retain that information.

So every time a beneficiary would submit a claim after that, they would, in essence, have to query that beneficiary again and again. That was one situation where we were talking about.

The other was the situation at Blue Shield in California that we discussed earlier where they had information on 50,000 beneficiaries, but due to a systems conversion lost it.

Mr. SUNDQUIST. So this is not Maryland. I want to make sure that that is clear.

Mr. DAVIS. No. That is not in reference to Maryland.

Mr. SUNDQUIST. Now, Ms. Gagel, was there any thought given at HCFA, and is it possible, given the huge amounts of money we are talking about in terms of loss to the system, of transferring funds from one area in HCFA into another area so you could continue to put resources where there is a 30-to-1 payback? Was there any thought given within HCFA to moving some people or administrative money so we could continue to have this 30-to-1——

Ms. GAGEL. The only funds that are available to do that, Congressman, are inside the contractor budget itself.

Mr. SUNDQUIST. Those are the only funds that would be available?

Ms. GAGEL. We have to use the funds that are appropriated in the contractor's budget. What we did earlier this year, indeed you may have been aware that we have a shortfall for this year, was request contingency funding, and we received $75 million.

We clearly made the choice at that time to slow down claims processing, if necessary, given inadequate funding, rather than reduce the funding support for the secondary payer program.

Mr. SUNDQUIST. Apparently from the carrier's standpoint, they say they could recover $17 for every dollar spent pursuing MSP mistaken payments.

Let me ask you, Ms. Gagel, or GAO or anybody who would like to comment, would it make sense for the Government to pay—it is about 5 percent, I think, return, 5 or 6 percent—for every dollar that was collected from the secondary insurer, that the contractor would keep 6 or 7 or 8 percent, whatever?

Ms. Jacoby, would that make sense?

Ms. JACOBY. On the surface, it sounds like it. I think I would like to see more details.

Ms. GAGEL. It would be kept at the contractor for purposes of using it to administer the Medicare program?

Mr. SUNDQUIST. For the purposes of collecting the money that you are not getting now or the money to give to you to give to them; right?

Ms. GAGEL. That is one option, yes, that we are looking at.

It would require legislation, clearly, to do that.

Mr. SUNDQUIST. I understand that. That is the purpose of this today, I think, is to figure out what to do to correct the problem because I don't think HCFA has been doing their job.

GAO?

Mr. DAVIS. One word of caution I would offer is, I think we would have to be very careful and have some controls in place to make sure that the contractor didn't let a lot go out the front end so that they could recover it at the back end.

Mr. SUNDQUIST. I understand.

That needs some very good controls.

Mr. DAVIS. Absolutely.

Mr. SUNDQUIST. But it seems to me that right now nobody is responsible.

Congress didn't put the money in, and so we are letting it happen, and then we are letting it happen though by law we cannot do that, we are doing it. And so it all comes back to Con-

gress, and it is our fault because we are trying to balance the budget.

And Ms. Gagel, if we were able to change the law so you could transfer funds, would there be funds that you would think would have higher priority or would have lower priority that you would transfer funds from one area to the other; would that help?

Ms. GAGEL. I am sorry, you mean from inside the HCFA budget?

There are only two sources of money. One is salary and expenses, and the other is essentially the contractor budget.

Mr. SUNDQUIST. How big is HCFA's budget?

Ms. GAGEL. I would have to provide that for the record. The contractor budget is by far and away the most substantial part of that. The contractor budget is probably about 75 to 80 percent of the HCFA budget.

[The information follows:]

HEALTH CARE FINANCING ADMINISTRATION

OVERVIEW

(Outlays in millions)*

	1989	1990	1991	1992	Change
Medicare.....	$96,554	$109,659	$116,267	$129,699	+$13,432
(Survey & Certif.)....	(86)	(112)	(183)	(187)	(+4)
(Proposed Leg).....	--	--	--	-2,982	-2,982
Subtotal, Medicare....	96,554	109,659	116,267	126,717	+10,450
Medicaid.....	34,605	41,103	51,555	59,899	+8,344
(Survey & Certif.)....	(63)	(80)	(130)	(146)	(+16)
(Proposed Leg).....	--	--	--	-67	-67
Subtotal, Medicaid....	34,605	41,103	51,555	59,832	+8,277
Program Management**....	91	79	83	--	-83
(Medicare Contractors)	(1,460)	(1,449)	(1,552)	(1,557)	(+5)
(Federal Admin.).....	(325)	(310)	(270)	(298)	(+28)
(Research).....	(51)	(50)	(70)	(36)	(-34)
HMO Loan & Loan Guarantee Fund.....	-3	-7	--	-5	+5
Survey and Certification:					
Medicare.....	(86)	(112)	(183)	(187)	(+4)
CLIA.....	(--)	(--)	(13)	(548)	(+535)
Medicaid.....	(63)	(80)	(130)	(146)	(+16)
Subtotal, Survey & Cert.	(149)	(192)	(326)	(881)	(+555)
TOTAL, Outlays.....	131,122	150,834	167,905	187,498	+18,639
Offsetting Receipts***	-11,590	-11,606	-11,833	-12,943	-1,110
TOTAL, Net Outlays....	$119,656	$139,228	$156,072	$173,601	+$17,529
Federal FTEs.....	*3,546*	*3,582*	*3,577*	*3,583*	*+6*
State Certification FTEs	*380*	*380*	*550*	*550*	*--*
TOTAL, FTEs.....	*3,962*	*3,962*	*4,127*	*4,133*	*+6*

* Numbers may not add due to rounding.
** Outlays from general fund appropriations; amounts in ( ) represent total program levels including trust fund transfers.
*** Offsetting receipts (net proposed law) include beneficiary premiums under Medicare Parts A and B.

Mr. SUNDQUIST. Now, GAO, or maybe I have asked this before, but let me ask it one more time. Does it make any sense to hold up on payments if the information is not furnished and therefore waive the interest requirement?

Ms. SHIKLES. We are looking at this issue. I think you probably should hold up on payments to make sure that the information is there.

Mr. SUNDQUIST. That is my question. Why?

Mr. DAVIS. I would like to add to that. I think that part of the solution to this whole problem is that we've got to start changing the mindset or the incentive system that is in place.

Right now, if you look at the penalty as you say for people not complying with this, usually the Government ends up paying if something isn't working right. And I cite the regulations that we discussed earlier.

If the contractors aren't efficient at getting this money back, it is not the contractors that suffer. It is the Federal Government that suffers.

Mr. SUNDQUIST. Absolutely. In fact, the contractors benefit.

Mr. DAVIS. Exactly.

Mr. SUNDQUIST. In this instance, Blue Cross and Blue Shield benefits.

Mr. DAVIS. We have got to start to change that incentive structure and put some pressures on other players in the game, the providers, for example, and the contractors.

Mr. SUNDQUIST. Mr. Chairman, I don't know how we proceed on this, but it seems to me that as we work through some legislation that we sure do need to get GAO involved in that process, so that the checks and balances are there so we can enforce it, and it makes sense.

So we don't have excuses for people not to do their jobs, and so it cannot be blamed on Congress. I don't think there is any question in the Congress, Mr. Chairman, if he said to our colleagues we can increase the budget by x amount here and we are going to get a 30-to-1 ratio, and it is quantifiable, and we tell the HCFA to administer it that way and that the contractors would have a penalty of triple damages and we waive the interest rule and say, we are not going to pay it unless the information is there, it seems to me that is what I would do in the private sector.

And I suspect that that is what all of you would do, also, if it was your business. You wouldn't be running it this way, and I don't think HCFA is running it correctly.

I have to be honest with you. Congress may be to blame for not funding it properly, but it seems to me that HCFA has been reticent in their enforcement.

And with that, that is all the questions I have, Mr. Chairman.

Chairman PICKLE. Mr. Sundquist, I think your questions have been very helpful and good ones, and I think Congress must also assume some responsibility and put a priority on it.

I can understand why HCFA has been a little hesitant because it is a very complex and large problem. But something needs to be done, and we all recognize that. And we are going to ask for full cooperation.

Mr. Anthony.

Mr. ANTHONY. Mr. Chairman, with your permission, I have a few extra questions.

Chairman PICKLE. You may proceed, Mr. Anthony.

Mr. ANTHONY. Following up with GAO on some of the inquiries that Mr. Sundquist has, in your investigations, have you ever run across instances where both Medicare and another insurance have paid for the same claim?

Ms. SHIKLES. Yes, we have. That is part of another review we are doing, and we have found that problem.

Mr. ANTHONY. Can you quantify the problem at this moment?

Ms. SHIKLES. No.

Mr. ANTHONY. Can you explain how it happens?

Ms. SHIKLES. We are finding it in hospitals. Mr. Davis, maybe you could elaborate. This work is still very preliminary. That is why I am hesitating.

Mr. ANTHONY. But you are looking into that problem?

Ms. SHIKLES. Yes, we are.

Mr. ANTHONY. Have you run across instances where Medicare has paid twice for the same procedure?

Mr. DAVIS. In that same effort, yes, we have. And again, it is too preliminary to quantify how extensive the problem is or what the cause is.

Mr. ANTHONY. Is there any punishment for those violations?

Mr. DAVIS. Not that we are aware of, no.

Mr. ANTHONY. In other words, if I am a provider and I provide a service to a beneficiary who has group insurance and a Medicare card, and I charge my formal rate for the service that I am providing, then I purposefully bill both Medicare and the third party payer and both pay under the circumstances as exist now?

Ms. Gagel, can you not punish them in any way, that provider? And if so, how can you punish them?

Ms. GAGEL. I think that would be intentional false billing, but I would have to look that up.

Mr. ANTHONY. If it is, what is the punishment?

Ms. GAGEL. They can be removed from the program.

Mr. ANTHONY. Do you?

Ms. GAGEL. I know of no instance, quite frankly, where that has happened for that reason, no.

Mr. ANTHONY. Would GAO tell us whether or not there have been instances where a provider has billed both an insurance carrier and Medicare for the same procedure? Mr. Simon, are you aware of any?

Mr. SIMON. I can answer that, Mr. Anthony. That does happen, not commonly, but there are some providers who will bill Medicare for a particular service and bill a private insurer, and that is punishable under criminal laws and in State courts and Federal courts.

If a Medicare claim is filed falsely, there are also civil penalities.

Mr. ANTHONY. Are you aware of any criminal cases that have been filed?

Mr. SIMON. More commonly what happens is if a provider wants to file false claims, he files for services not provided.

Mr. ANTHONY. For services not provided?

Mr. SIMON. That is correct. That is clearly fraudulent. I am just talking about where you have billed both carriers for the same pro-

cedure. GAO is looking into it, and I assume that a further study will come out that will expand upon this inquiry.

Ms. SHIKLES. Yes, we are doing a study now particularly focused on hospitals.

We are finding that it is happening, but we are still in the early stages of our work. We don't know if it is isolated to a few hospitals or whether it is a systemic problem.

When we are further along in the review, we will report to you.

Mr. ANTHONY. I don't know if your review is broad enough, but if it is not, I would ask you to expand. Once you found those cases, could you go over to HCFA, find out if they were aware, and if they were aware, what patient was taken? I would like to have a record as to whether or not anybody has been removed from the roles for that type of conduct.

Ms. SHIKLES. We will do that.

Mr. MANGANO. Mr. Anthony, if I could just add to that, we did a study a couple of years ago entitled "Medicare Credit Balances," in which we did basically what you are asking for, and that was to take a look at credit balances that were on hand in hospitals, primarily because they had billed two parties at one time. We have turned that information over to HCFA, and HCFA has made recovery of it.

Mr. ANTHONY. That is good. I applaud HCFA for doing that.

Ms. Gagel, I have got one live case from the State of Nevada. For the years 1989 and 1990, 153 separate claims on one beneficiary, total $41,776.80. The contractor's data files indicate that another insurer was primary and should have paid these 153 claims. To date, the contractor has taken no action to recover.

It is my understanding that HCFA itself has internally a $250 per claim tolerance under part B. Of these claims, 129 were worth $8,500, and would be below your tolerance level, so therefore would slip through the cracks and would not have any administrative recovery mechanisms incurred.

Could you explain this particular case to me about——

Ms. GAGEL. I would think in a case like that, where we have the complete identification, we would attempt to do a full recovery.

Mr. ANTHONY. I am asking two questions here. The primary question to you is, what is the status, the logic, and the rationale behind the $250 tolerance? In other words, it appears to me that even if the contractor had gone after these other payments, under HCFA's own tolerance level there is $8,500 that you are willing to forgive. I assume you are making some judgment internally that it is just not worth the expenses to go after a multitude of claims all across America, with the millions of pieces of paper and claims that you get, and, therefore, you are trying to put some arbitrary management level on it.

I assume that is what you have done. Am I correct in my assumption?

Ms. GAGEL. No, you are not.

The $250 relates essentially to the development. It is a trigger for when we have to develop the case, when we are not sure whether or not someone has other insurance. Once we learn that someone has other insurance, that information is put in the file, and then all subsequent claims on that person——

Mr. ANTHONY. Are checked?

Ms. GAGEL. There is no tolerance level on that at all, there need not be, because it will certainly cost less than $250 to recover in those cases.

Mr. ANTHONY. I will instruct staff to give you this material.

Ms. GAGEL. Please.

Mr. ANTHONY. You can check your files to see if you are working on it. I would trust that, without question, you would correct it, but it is somewhat disturbing that over a 2-year period Medicare paid that many claims, that much money for one beneficiary. I think it may shock a lot of people to realize that this is the kind of money that is flowing through the Medicare system. So it is not like there is one person out there trying to rip off millions.

There are millions ripping off a little. I think we have got to do something about it.

Just two other quick questions for HCFA.

Contractors seem to devote a lot of their time to first claim development. Budget constraints, do you think there will be any pressure to eliminate first claim development or does HCFA support first claim development and would encourage them to keep it in place?

Ms. GAGEL. First claim development is far and away the most cost-effective means we have at the moment of administering the secondary payer program.

What we are doing is examining first claim development and the way it is being administered at each of the carriers to make sure they are doing it in the most efficient way.

Mr. ANTHONY. So you do support it?

Ms. GAGEL. Yes.

Mr. ANTHONY. No plans to eliminate it?

Ms. GAGEL. No.

Mr. ANTHONY. Maybe possible plans to expand it into hospitals?

Ms. GAGEL. It is now done. It was expanded to the part A side of the program in December.

Mr. ANTHONY. In December it was expanded. That is wonderful.

What problems do the carriers encounter when they try to recover from insurance companies? Are they slow pay?

Ms. GAGEL. Slow pay is not the problem. The issues that they get into is whether or not indeed the company was primary or secondary. There are disputes——

Mr. ANTHONY. I am taking you one step beyond that. Once you have resolved a dispute and you know that they owe you the money, do you have any problems after that?

Ms. GAGEL. No, I am not aware of. I think generally once the dispute is over, the funds are forthcoming relatively quickly.

Mr. ANTHONY. Inasmuch as you have got this chase-and-pay mentality out there and the way they slow the process down is to ask you for every single piece of paper that has ever been laid out in the file, and then they rethink it, then they transfer the person that was working on the case file, and then they lose the file, then they ask somebody else to look into it. By the time you get through, you have probably run out of duplicating paper and worn out a Xerox machine.

Can you think of anything that we could do to make it easier to collect once an erroneous payment has been made to a doctor, and what do you think of allowing the contractors to seek recovery from the provider?

Ms. GAGEL. They do now generally seek recovery from the provider if it is determined that the provider has been paid twice. There is a set of rules that they follow. They go first to the provider, then second to the beneficiary.

Mr. ANTHONY. Do we do anything under fines? As part of patient, if you find somebody that has——

Ms. GAGEL. No.

Mr. ANTHONY. I would ask you to work with our staff in this overall review program to see if there is a logical place where an extra incentive could be lodged without being oppressive in the market but would be intended to improve the carrier and the contractor's position, which ultimately then is the taxpayer's position.

I know it gets very delicate trying to balance that out, but it appears we might be missing an opportunity here, so as we review this, I would like to work with you in that regard.

Ms. GAGEL. OK.

Mr. ANTHONY. That is all I have, Mr. Chairman.

My final thanks to the panel for their testimony.

Chairman PICKLE. I thank you, Mr. Anthony.

Do you think there is a—any of you—think there is a conflict of interest with respect to the selection of an insurance company solely to be eligible to participate in this program if they are both a carrier and an overall insurance company, too?

In the case of Maryland, Blue Cross and Blue Shield, I think, showed that 84 percent of their claims were claims that they owed themselves, that their company hadn't paid?

This raises a question to me, is there a conflict of interest there in saying that an insurance company can only qualify as one of these contractors or carriers?

Any of you venture a philosophy on that?

Ms. GAGEL. I think there is an inherent conflict of interest.

Chairman PICKLE. How do we solve that?

Ms. GAGEL. Either I would think by requiring the data match so that the opportunity to take advantage of the conflict is minimized or by expanding the legislation so HCFA is not compelled to contract only with insurance companies to administer this program.

Chairman PICKLE. Would you venture to give me some group that, say, could qualify?

Ms. GAGEL. Pardon me?

Chairman PICKLE. Can you give me an indication of what kind of group would qualify as a carrier or a contractor?

Ms. GAGEL. Probably any large bill processing operation. I would think anybody who has a large computer-based operation that sequentially, if you will, makes payments or analyzes information coming in and puts them together.

Chairman PICKLE. I don't have any group in mind for this task, but I think we must ask ourselves if only insurance companies qualify, and I am glad they do qualify, but if we find also that a large number of claims are being unpaid by their own company where they are carriers, then there is a weakness there, and if that

is happening in Maryland, it is bound to be happening in all the carriers across the country.

I think it is something we need to look into. I don't want to drive the insurance companies out of the business. We must be frank to admit that we need their help and cooperation, but just by itself I think that raises a question.

If any of you have any viewpoint, I would like to have it, to hear from you.

Ms. Gagel, let me ask you, what do you think of the idea of allowing the carriers, the contractors and carriers under part B to recover erroneous part B payments from the providers, from the doctors?

Ms. GAGEL. We require them to do that now. I think that would be appropriate.

Chairman PICKLE. I didn't know they were required to do that. I have to ask myself why does HCFA instruct the carriers to seek recovery from the insurance company rather than the providers, from the doctors? Do you do that now?

Ms. GAGEL. Yes.

First, they go to the insurance company. There is a sequence of activities here, and I am not exactly sure how they go.

But in part B, first the involvement goes back to the insurance company who did the erroneous payment. In the event that we cannot get it there, then I think we revert to the provider.

Chairman PICKLE. Then if you do that—I won't pursue that question.

I thought you did not do it and that you might or might not do it, but you say they are required, that you can get from a doctor as well as from the insurance company and that you pursue that.

Now——

Ms. JACOBY. Mr. Chairman, could I comment on that procedure, please?

Chairman PICKLE. Yes.

Ms. JACOBY. Ms. Gagel is right. The first thing we do is contact the insurance company and ask them if they have paid the same claim we did. If we find out that both of us made a payment, then we, as the Medicare contractor, go to the payee, whether that be the provider or the beneficiary, and recover from them.

If there has been no payment made by the EGHP, then we try to recover our money from the EGHP.

Chairman PICKLE. Well, I am glad that that is the general procedure, but I thought that we did not follow that, and I am glad to have that clarification. But at least you attempt to do that under present procedures.

All right. Now, let me ask Ms. Shikles, in an earlier report you recommended that HCFA should tighten up on its performance evaluation standards for contractors to better ensure compliance with these MSP standards. Do you have any specific suggestions how to give incentives to contractors to recover more mistaken payments?

Ms. SHIKLES. Well, this gets back to our general concern about the MSP program. We don't think it is just a funding problem. We also want HCFA to develop a strategy on exactly what they expect of the program. As I mentioned, each carrier has a different set of

problems, so even if you get additional money, you wouldn't want to do across-the-board funding increases.

I think you want to figure out at each carrier what the problem is, develop a very explicit strategy on exactly the staff they need, set milestones, and then maybe impose contract penalties if they don't proceed to recover quickly.

Mr. DAVIS. I would like to add to that, if I could, Mr. Chairman.

In response to your question about evaluation, as far as getting these mistaken payments back, I think perhaps HCFA might want to consider specific evaluations standards for that particular effort. That may help the situation.

Chairman PICKLE. Yes, it might help.

I thank you for that clarification.

Now, I want to ask a broad question now. At the very beginning it was suggested, I think by Ms. Jacoby, that we try to get information when a person first becomes eligible for Medicare, and I guess this would be a question more for HCFA than anybody else.

When we inquire of the person, could we ask these kinds of questions, is there any reason why we shouldn't get this answer? For instance, should we ask SSA to ask the beneficiaries such questions as this, are you employed, and if so, do you have health insurance? Is there anything wrong with asking that question?

Ms. GAGEL. No. In fact, we recommend it.

Chairman PICKLE. All right.

Second, is your spouse employed, and if so, does either he or she have insurance, shouldn't we ask that question?

Ms. GAGEL. That is right, yes.

Chairman PICKLE. At the very beginning, ask it.

Third, would we ask what is your spouse's Social Security number, should we get that and make it a matter of record for taxing purposes later?

Ms. GAGEL. That would be very helpful, yes.

Chairman PICKLE. Shouldn't we also finally say at that point, if you make any change in your employment, you should notify us that that is done, either that you have a job or that you have changed jobs or you change to a health group or anything else, in other words, if you change at some later point, you are required to notify Social Security of that.

Is that an unreasonable request?

Ms. GAGEL. Not at all, sir.

Chairman PICKLE. All right, then, if we had those four basic questions to ask at the beginning, that would establish a lot of basic information, though there would be changes, we are saying to you, we are glad to have this information, now if you change a year or two or three later, notify us, and that would not be an onerous burden on anybody's part; would it, really?

Ms. GAGEL. No, but you need to understand there is substantially more information that HCFA and a Medicare contractor need in order to establish a Medicare secondary payer situation. So those are four very good, very basic questions.

Chairman PICKLE. Do you have any other suggestions?

Ms. GAGEL. Essentially, all they do is tell us everything else that we need to ask that same beneficiary with regard to MSP. We need to know the kind of insurance. We need the policy number. We

need to know the kind of employer, because not all employers who employ aged people fall under the MSP provisions.

So that is why, as an alternative, HCFA is thinking about sending out a questionnaire to all beneficiaries as they enroll that would ask that second series of questions which are much more specific. Then we would have good, complete information in our files and would not have to do follow-up when we receive a claim.

Chairman PICKLE. I don't want to quiz a person so much that they think we are trying to interrogate them as though we think we are suspicious of them to begin with. I don't want to overdo it, but we are so neglectful in asking information now that we have got to get the right questions.

If you have any specific questions, I wish you would notify our committee.

Ms. GAGEL. I would be pleased to do that.

Chairman PICKLE. Mr. Sundquist.

Mr. SUNDQUIST. Thank you, Mr. Chairman.

Ms. Jacoby, I understand that in previous testimony you talked about the audit at Johns Hopkins Hospital, about the out-patient admissions procedure.

Could you comment on that real briefly in terms of how they were coding for "unemployed."

Ms. JACOBY. At the time of the audit, and I should say I am speaking from what my investigator found, not from my own personal experience, but when we conducted the audit, we found a small yellow Post-it note taped to a terminal at the Hopkins billing office with a note on it that said all Medicare claims must include condition code 09. Condition code 09 indicates that we have asked the questions and Medicare is, in fact, primary, that is what the providers are telling us when they use that code.

Mr. SUNDQUIST. Well, in fact, when that was on there, does that mean unemployed and did that mean it would go through faster? Is that the net effect of that?

Ms. JACOBY. Not necessarily because if we had conflicting information in our data base, we have some information that says there is another employer involved or the CWF auxiliary record has some information, the 09 by itself will not make that claim go through. If we have no other information on our files, it will go through, yes.

Mr. SUNDQUIST. Chances are the reason they were doing that, though, is it was able to sail through more times than not?

Ms. JACOBY. I can only speculate.

Mr. SUNDQUIST. Would I be unfair if I speculated that that was probably true? Or they wouldn't put up a note like that?

Ms. JACOBY. Yes, I think so.

Mr. SUNDQUIST. OK.

Now, if we put a secondary payor information on the revised claim form, Ms. Gagel, should we put on there—have on there notification and should there be some penalty for critical omission, and should we add to that some penalty for misinformation?

Ms. GAGEL. What type of penalty are you suggesting?

Mr. SUNDQUIST. I don't know. That is what I am asking you.

Ms. GAGEL. OK.

Certainly, any time someone provides us with incorrect information or incomplete information, it clearly increases the cost of operating the program.

Mr. SUNDQUIST. What I am talking about is misinformation or critical omission. If they know that there are secondary payers and they don't put that on there or in this case if it is misinformation, I mean, shouldn't there be some penalty?

Ms. GAGEL. If it is intentional—I think there is a very fine line between when a provider is intentionally giving us incorrect information or inadvertently doing that because incorrect information was given to him.

Let me give you——

Mr. SUNDQUIST. I think that goes without saying, but I think the difference would be a pattern, would it not, maybe a note sheet up on the board saying put this in there?

Ms. GAGEL. Certainly, if there is a pattern, very aggressive action can be taken.

Mr. SUNDQUIST. Under present law?

Ms. GAGEL. Under present law, certainly. That is what Mr. Simon was referring to earlier.

Mr. SUNDQUIST. But he said we couldn't do it because the Justice Department didn't think it was—it made sense, as I recall.

Mr. SIMON. Well, that was with respect to the Provident Life, an accident insurance company case.

Mr. SUNDQUIST. Have we done this with anybody? Have we ever done this, where there has been any misinformation or omission that we——

Mr. SIMON. Not in this setting where they are making a choice between billing Medicare or a private insurance company, as I understand what you are saying.

But I would suggest that if someone knowingly bills us falsely that that meets at least three corners of the criminal statute.

I think, though, that if you would—if we set the stage——

Mr. SUNDQUIST. What if we put the secondary payer information on the revised form and people don't pay, what would you do?

Mr. SIMON. I think there should be some penalty for the negligence aspect of it.

Ms. GAGEL. At the moment, what we do is process the bill and develop that information ourselves.

Mr. SUNDQUIST. Do you ever get anything back when you process it?

Ms. GAGEL. Yes, when we develop it, yes, we get information back about whether or not other insurance is available.

Mr. SUNDQUIST. This is the big refund we are going to get back in my January of next year. This is part of that?

Ms. GAGEL. No. No. No.

Mr. SUNDQUIST. So we don't have—you don't have secondary payer information on the form now; do you?

Ms. GAGEL. Yes, we do. Yes, we do.

In some cases, but as you suggest, in not all cases does the provider fill out that section of the form. When the provider fails to fill out that section of the form, we either develop it ourselves or we go ahead and process the bill.

There are a couple of things we could do. We could send it back to the provider and say fill out the form. That will have the practical effect of slowing down payments to providers in this country very, very, dramatically, and it will have a major cash flow effect on hospitals and other health care institutions in this country. That is why we have been reluctant to take that kind of action.

Mr. SUNDQUIST. Well, what about some penalty for critical omission, then, if they are not filling it out and there is no downside penalty for not filling it out? It seems to me that you are bearing the brunt, we are as taxpayers, of their not filling it out and there is no reason for them to fill it out if we are not going to make them fill it out.

Why have it on there to begin with if we are not going to make them fill it out?

Ms. GAGEL. We were certainly hoping for voluntary compliance, and we receive it from most hospitals in this country.

Mr. SUNDQUIST. On what percentage?

Ms. GAGEL. On in-patient bills and hospitals, we have very good compliance. It is up in the 70-percent range.

For out-patient services and hospitals, it is generally fairly poor. That is because the billing services at the hospitals, the actual accounting systems and bill arrangements that the hospitals have in this country, are not very sophisticated, and many of them are simply not capable of doing that right now.

Chairman PICKLE. Can you correct that?

Ms. GAGEL. We can't. It would be up to the hospitals in this country to do it. They need to change their billing services and accounting services.

Chairman PICKLE. We will look into that, too.

Ms. GAGEL. Quite frankly, they are starting to do that slowly.

Mr. SUNDQUIST. One last question, Mr. Chairman.

Ms. Gagel, when the Social Security law is such that when people pass a certain age, I think it is 70, I think they can make unlimited income without any penalties. It is at that point they are more likely to go back to work.

Has GAO done anything to figure out if that is an area where we ought to be doing some more sampling in terms of getting information for people who are employed and going back to work and having insurance? In other words, is that a more fruitful area to audit and sample?

Ms. GAGEL. Our experience is, in fact, essentially the opposite, that the working people tend to be people 65, 66, 67, and it drops off very, very dramatically after that age.

Mr. SUNDQUIST. Could you furnish this subcommittee with that information?

Ms. GAGEL. Yes.

[The information follows:]

DISTRIBUTION OF AGED WORKERS
Ages 65-79

AGE	EMPLOYED INDIVIDUALS
65	559,000
66	455,000
67	380,000
68	368,000
69	297,000
70	252,000
71	178,000
72	179,000
73	145,000
74	120,000
75	109,000
76	89,000
77	60,000
78	54,000
79	39,000

Source: Bureau of Labor Statistics
1990 Data

Mr. SUNDQUIST. Thank you.

Thank you, Mr. Chairman.

Chairman PICKLE. Well, thank you, Mr. Sundquist.

I want to thank the panel as a whole for your statements and for your suggestions. I think this has been a good hearing and we have adduced some good suggestions about how to proceed.

I think a lot of our problems stems from the fact that we don't have enough information at the very beginning, and we don't have any way of checking one against the other.

We didn't know this was going to be as big a problem when we first started. Maybe we should have, by hindsight, said that should have been done. We know now we need more information up front. We know now we need to get more information from the hospitals, both in-patient and certainly on out-patient. I think we know also that we have got to pursue erroneous payments.

I think it is natural to assume that private insurance companies are going to take more time to ask more questions about a claim than the Government. After all, it is their money, and they want to make money. They are not in the habit of just giving it away too easily, so I understand that. There is nothing wrong with that, but a lot of them also, we find, are terribly slow and maybe purposely slow, and over the years what has probably developed is that the slower they are, the more apt be it that Medicare gets billed.

It is easier for the hospitals just to bill Medicare . It is easier for the physicians just to bill Medicare because they get the money. I think that is the development.

I am not asking you to agree with that, but I think that is a fact, and we have to recognize it. If it is a fact, then we have got to set about making some changes.

I want to make this closing statement because—I make it now more or less in coordination with what our chairman has indicated.

During this Congress, Chairman Rostenkowski and I, in representing the Oversight Committee, have agreed to aggressively identify and examine those programs under the jurisdiction of the Ways and Means Committee that are not being used efficiently or which are not effectively achieving their goals.

It is a big issue. We are going to look at it throughout the year. This is just one specific case that we—one problem that we are approaching.

It looks like the MSP may be one of those programs. Everybody seems to agree that it is leaking Medicare money. We just don't know how much. Perhaps as much as $1 billion.

There are leaks in the system when bills are erroneously submitted to Medicare because other primary insurance has not been properly identified. Some of these leaks are caught. If we could just stop all these leaks on the front end of the system, we would be assured that no more erroneous payments were made, or at least we could keep them in a minimum.

In the meantime, however, we have already let a substantial amount of Medicare money flow out of the system. Even if we developed a perfect system, making sure that not one more claim was submitted to Medicare when it should have been submitted to another insurance company, we would still have a substantial recovery effort to undertake.

So, we need to develop a two-pronged strategy, as I see it, first, to stop MSP claims from being submitted to Medicare, and, second, to get some of the Government's money back. Those are two primary goals that I think we should pursue.

This subcommittee, then, since we have put priority on this particular question and it is sort of the first of the type of issues we are going to be examining on the basis of efficiency and effectiveness for the year, I hope we can put a great priority on solving this question.

For that reason, I am asking you people to work closely with our staff. We are going to submit to you additional questions that we haven't gotten here this morning.

I think this has been a good hearing with some valuable information. This has not been a hearing for the purposes of criticizing any one agency on what is happening, but we know that the fact is that our procedure is flawed and it is slow, and it is overlapping, and it has got to be changed.

I am asking you to cooperate. Mr. Anthony and Mr. Schulze are going to be working primarily with our staff and with you. We will be asking you to come together with us again perhaps as early as next week with a review of trying to come to some kind of conclusion between now and April 15.

I would appreciate your suggestions. I certainly appreciate your testimony this morning.

If there are no other questions, then the committee will stand adjourned.

[Whereupon, at 12 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

AGPAM AMERICAN GUILD OF PATIENT ACCOUNT MANAGEMENT

March 12, 1991

Robert J. Leonard
Chief Counsel
Committee on Ways and Means
U.S. House of Representatives
Room 1102
Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Leonard:

I am writing on behalf of the American Guild of Patient Account Management (AGPAM) concerning the Hearing on Mistaken and Uncovered Medicare Payments. The press release of Wednesday, February 20, 1991, pointed out some of the problems Medicare Fiscal Intermediaries have in dealing with post payment recoveries and identifying Medicare Secondary Payment accounts.

It has been the experience of our members, nearly 4,000 professionals who manage the billing and collection of healthcare accounts, that the primary source of this problem rests with the Fiscal Intermediaries processing system. Hospitals, clinics and individual physician offices throughout the country have been submitting thousands of requests for payment corrections each month. The Intermediaries have not complied with these requests because their automated payment systems do not contain an easy and timely method for correcting payment errors. As a result many medical providers have had to establish special reserve accounts to identify and track the many credit and debit requests that Medicare Fiscal Intermediaries have not been able to process.

These system problems need to be identified and corrected immediately in order to correct this backlog of debit and credit requests that many Medicare Intermediaries currently possess. AGPAM is eager to supply specific cases and/or testimony to support our stand on this position. If we can be of any assistance in correcting this problem that affects our members please feel free to contact me. Thank you.

Sincerely,

Clayton E. Cieslak

Clayton E. Cieslak
Legislative Chairman

CEC/jcg

STATEMENT OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

The Health Insurance Association of America appreciates the opportunity to contribute to the record of the Subcommittee on Oversight's hearing on "Mistaken and Unrecovered Medicare Payments."

Several of our member companies are intermediaries or carriers for the Medicare Program. Most of our companies either insure employer group health plans (EGHPs) or administer claims for self-insured employer plans. Thus, we are well acquainted with the problems that both Medicare and EGHPs encounter in trying to assure that Medicare is the secondary payer of benefits for certain Medicare beneficiaries who are working and have employee health benefits or are covered as dependents under the employee health benefit plan of a working spouse.

The comments that follow are based upon our review of the witnesses' written statements and the dialogue that took place at the Subcommittee's February 26 hearing. We hope they help the members in understanding the nature of the problems that were discussed and in analyzing what ought to be done to improve the level of performance of Medicare's MSP program.

At the outset we would like to comment on the use of the word "mistaken" in characterizing the payments which Medicare seeks to recover through its MSP program. The vast majority of the payments in question were not made in error. The claims were paid on the basis of Medicare being primary because conclusive evidence was lacking that Medicare should have been secondary payer. Because the government did not want to disrupt the processing of claims and the flow of payments to providers of care, it adopted the explicit policy of paying such claims as primary and, when information was developed later making it clear that it should have been secondary payer, to then seek recovery of the inappropriate payment. This government policy was known as "pay and chase". It was a deliberate administrative strategy.

The idea behind the Medicare Secondary Payer program is a simple one - when a Medicare beneficiary is covered by an employer's group health benefits, Medicare could save a lot of money if the employer plan is required to pay first and Medicare only pays any covered benefits not paid by the employer. No doubt, the authors of this cost-shifting strategy envisioned that all the information needed to assure that Medicare paid secondary could be obtained when beneficiaries visited the doctor or hospital and that information would then simply be included on the claim form sent to Medicare for payment. As things turned out, beneficiaries, for a variety of reasons, very often do not provide the needed information and providers of care do not or cannot properly report it. Nor do the Medicare forms ask the right questions to generate the information. This has resulted in the development of a variety of complex and labor intensive administrative procedures for Medicare intermediaries and carriers who must seek clues and follow up on them in order to establish whether or not a Medicare beneficiary was covered by an EGHP on the date that he or she received care.

The Essential Problem

Despite the fact that MSP activities consistently save the government an average of more than $11 for every dollar spent on them, the Administration and the Congress have been unwilling to fund those activities adequately, resulting in hundreds of millions of dollars in "mistaken and unrecovered Medicare benefits." As Ms. Shikles of the General Accounting Office pointed out, the Administration proposes to spend $10 million less on MSP activities in FY 1992 than was spent in FY 1989, a year in which the number of claims received by contractors was thirty percent lower than it will be next fiscal year.

The overriding problem to be resolved in the Medicare Secondary Payer program - and the key to making the program operate efficiently - is for the Congress to provide adequate funds to do the job. Intermediaries and carriers do not have the

staff to cope with the MSP workload and the Health Care Financing Administration's overall budget for its contractors operations is so tight that it is impossible to reallocate sufficient funds from other essential activities to strengthen the MSP effort. For FY 1992, the Administration proposes to spend $70 million on the MSP program. To do the work needed, that figure should be raised to $125 million.

The GAO reported that, due to insufficient funding, even when some contractors learn that a beneficiary has other coverage, they are not researching their files to identify inappropriate primary payments that may have been made. Other contractors are identifying improper payments but not proceeding to recover the funds. These are not atypical situations. Across the country, cutbacks in funding have resulted in contractors laying off the staff needed to adequately perform their MSP duties. Ms. Gagel of HCFA testified that at the start of FY 1991 there was a nationwide backlog of 863,000 MSP cases estimated to be worth $218 million. This backlog is not due to ineptness or inefficiency on the part of HCFA or its contractors. It is the direct result of federal budgetary restraints. The Congress and the Administration, in their efforts to contain federal spending, have so limited the funding of Medicare administrative activities that it is impossible to do the work needed to effect recoveries.

Contractors have also been hampered by constant shifts in direction from HCFA concerning which specific MSP-related activities should be performed with the limited funds available. During the past year, for example, a considerable amount has been spent on historical research in support of the government's MSP litigation rather than on MSP review of current claims.

Hundreds of millions of dollars are going unrecovered annually because the federal government has not recognized that spending an additional dollar in Medicare administrative costs will avoid making or recover $11 in inappropriate benefit payments. One reason for this state of affairs is that the Congressional budget and appropriation processes score a dollar to be spent on MSP against Congressional spending ceilings, but do not offset the expenditure by taking into account the $11 in documented savings it will produce. It is within the power of Congress to permit increased MSP funding by recognizing those savings. Until it does so, or until it authorizes some alternative mechanism which will enable a portion of MSP recoveries to be "recycled" to fund contractors' MSP operations, it is unlikely that adequate funds will ever be available and the problems highlighted at the Subcommittee's February 26 hearing will continue to grow.

Do Medicare Contractors have an MSP Conflict-of-Interest?

Under present law, Medicare intermediaries and carriers are required to be insurance companies. Mr. Mangano of the GAO recommended that these contractors should be required to match data from their private health insurance business against Medicare claims data in order to identify MSP cases among their private business. Mr. Mangano believes that contractors have a fiduciary duty to assure that only appropriate claims payments are made, and that by refusing to perform this data match they are breaching that fiduciary duty and have a conflict of interest between their private and government activities.

We would like the record to show that we strongly disagree with the Office of the Inspector General on this issue. The Congress also disagrees. As Mr. Mangano mentioned, in OBRA '89 it prohibited HCFA from imposing such a data match on its contractors.

With respect to their private health insurance business, Medicare intermediaries and carriers have the same obligation to cooperate with the Medicare Secondary Payer program as all other health insurers. The fact that they contract with the government to perform Medicare administrative tasks should not work to their advantage or their detriment. If contractors perform the data match desired by Mr. Mangano, they will incur administrative expenses and claims costs to which their competitors in the health insurance market are not subject - clearly putting them at a significant disadvantage. This was the rationale for the OBRA '89 prohibition of a contractor data match.

Changing the Medicare Claims Form

The Office of the Inspector General recommends that Medicare claims forms be changed so as to require a specific "yes" or "no" answer to the question, "Do you have health insurance as a result of your or your spouse's current employment?" If the question is left unanswered, payment of the claim would be suspended.

We concur with this change in claims procedures. It is a simple and effective measure that would probably have been taken long ago had it not been outweighed by HCFA's concern that providers of care be paid promptly.

In our private business, we find that providers of care are generally very careful to obtain full information from patients concerning their insurance coverage. Refusing to pay Medicare claims submitted with incomplete MSP information would be a potent incentive for both providers and beneficiaries to cooperate more fully with the program.

Indicating Employee Health Benefits on the IRS W-2 Form

OBRA '89 authorized the matching of W-2 data with Social Security eligibility records and Medicare claims files. This exercise will begin producing results later this year and will provide a much improved picture of persons who are employed or are the spouse of someone employed, are enrolled in Medicare and for whom Medicare has received claims. It will not, however, show whether the identified persons have employer-provided health insurance. The Office of the Inspector General recommends that the W-2 form submitted to the Internal Revenue Service by employers be modified to show whether an employed person has health insurance benefits and whether coverage is also provided for dependents. This added information would vastly simplify the detective work needed to determine whether it is likely that a Medicare claimant had private coverage at the time services were provided. We believe it is an excellent idea - in fact, it has also been suggested to the government by our member companies.

Establishment of a Federal Clearinghouse

The President's budget proposal for FY 1992 suggests that a federal clearinghouse be established to acquire data from employers and/or insurers on employer-provided health benefits. This data would be submitted quarterly and would be made available to Medicare, Medicaid, The Department of Veterans Affairs, CHAMPUS, the Indian Health Service and any other government benefit programs which, by law, have been made secondary to employee health benefits. The Administration estimates that the federal cost of this activity would be $5 million annually.

We cannot support this proposal. While, arguably, a clearinghouse might be an efficient way for the government to obtain current information on federal program beneficiaries who have private coverage, we believe the cost to the private sector of gathering the data, putting it into the format dictated by the

government and submitting it quarterly would cost the private sector hundreds of millions of dollars annually.

Like the government, employers are also faced with rising health benefit costs. They should not be burdened with the administrative expense of a government cost-shifting strategy which is of no benefit to them or their employees. It is the government that benefits by making itself secondary payer. Therefore, it is appropriate that the cost of producing that benefit be borne by the government.

The most a data clearinghouse would accomplish is to show that a beneficiary had employee at some time within the last ninety days. It would be just one step better than including the data on the W-2 Form. Money and effort spent on a clearinghouse would be better spent assuring that the necessary information is included at the time a claim is filed. Not only would this be less expensive, it also would put the burden of providing the information on the parties receiving the payment.

"Voluntary" Disclosure and Recovery Program

The Office of the Inspector General suggests that legislation be enacted to set up a program under which insurers, employers, and third-party administrators could voluntarily identify instances in which they should have been the primary payer of a Medicare claim and make restitution (with interest) of the amounts due without threat of further government action. Insurers not participating in the program would be penalized by treble damages if inappropriately paid claims are identified later by the government.

We do not believe that a punitive program of this type is appropriate or necessary. The assumption underlying it seems to be that insurers and employers have knowingly accumulated inventories of claims for which they let Medicare pay first when they knew that Medicare should have been the secondary payer. This is not a pattern that we believe has occured frequently. The basic problems of the MSP program are not due to malfeasance in the private sector. Rather, they are the result of the government not spending enough to produce the magnitude of MSP savings it desires, and its failure to make several simple procedural changes that could greatly improve the program's performance.

In most cases in which the government questions whether a Medicare beneficiary had private coverage, we find that the private payer never received any claim for benefits. Thus, not knowing that health care services had been provided, they had no way of knowing at the time, and still have no way of knowing, that they should have been primary payer.

There would be tremendous expense connected with researching millions of past claims to identify possible instances of inappropriate secondary payment. Unless a payer has reason to know that they have large numbers of such claims, for which treble damages would result in a huge liability, they are unlikely to undertake the substantial expense of the necessary claims review.

We suggest that, if a program of this type were to be developed, it should apply to situations in which there is a clearly established, intentional and substantial pattern of private benefits being paid on a secondary basis when they should have been primary. Occasional mispayments which come to light should not be subjected to damages.

Careful consideration needs to be given also to the retroactivity of a such a program. There was a seven year gap between the effective date of the law and the publication of

final regulations informing private payers in detail of their legal obligation to be primary payer in specified circumstances. During the first two or three years neither the government nor the private sector were in a position to make MSP work. There were instances in which payers who felt they should be primary called HCFA to ask where to send the check and were told not to do so because the government wouldn't know what to do with it. We do not suggest that if such a program were adopted it should only be prospective in nature, but a reasonable point between the law's January 1983 effective date and the present time should be fixed as the date prior to which claims would not be subject to the program.

We hope the Subcommittee will find these comments useful as they consider what legislative improvements ought to be made in the Medicare Secondary Payer program. The Association would be pleased to respond further if members of the Subcommittee or their staff have questions or would like further information concerning MSP and its impact on Medicare contractors, employers or private health insurers.

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STATEMENT BY ROBERT J. MYERS PRESENTED TO THE SUBCOMMITTEE ON OVERSIGHT OF THE COMMITTEE ON WAYS AND MEANS, HOUSE OF REPRESENTATIVES, FEBRUARY 26, 1991 WITH REGARD TO MISTAKEN AND UNRECOVERED MEDICARE PAYMENTS

Mr. Chairman and Members of the Subcommittee: My name is Robert J. Myers. I served in various actuarial capacities with the Social Security Administration and its predecessor agencies from 1934 to 1970, being Chief Actuary for the last 23 years. In 1981-82, I was Deputy Commissioner of Social Security. Then in 1982-83, I was Executive Director of the National Commission on Social Security Reform.

I thoroughly agree with the concern of the Subcommittee about Medicare Secondary Payment (MSP) provisions not being adequately enforced, especially as to persons aged 65 and over who are working and are covered by an employer-sponsored health benefit plan. However, in this MSP area there is an instance that I would like to call to the attention of the Subcommittee where the health Care Financing Administration has ruled far outside of what I believe to be the congressional intent -- and, indeed, beyond what is reasonable and logical.

The portion of the HCFA rule with which I disagree strongly is that which deals with the interpretation of the phrase "active individual" as including disabled persons in some instances. It is anomalous to say that a permanently and totally disabled individual can, under any circumstances, be considered an "active individual" because of an arbitrary and illogical interpretation that he/she is an "employee" (as a result of meeting certain irrelevant conditions as to be classified as an "employee" when such is not the case by any reasonable or common-law definition of that term).

As a result, under the basis presented in the rule, many disasbility pensioners under private pension plans who, by no stretch of the imagination could be considered as "active individuals" or "employees", are arbitrarily so designated -- and Medicare improperly becomes the secondary payor. Nothing in the law or the legislative background justifies this treatment.

For example, such a situation occurs when the employer generously (or by necessity, because of state law or collective bargaining) gives a legal guarantee of reemployment if the disability pensioner recovers. Such a guarantee is certainly humane and socially desirable and should not be discouraged against by having the result be that the employer plan becomes the primary payor as against Medicare.

Further, the rule anomalously states that such status as an "active individual" or "employee" is applicable if "Participation in any employer benefit that is available only to employees" is present. There is "circular definition" here, because the employer could logically say that the plan is not only for employees, but rather is for both employees and disabled pensioners. And several other illogical situations result under the rule.

In summary, I urge that the definition of "active individual" be changed so that it includes only persons who are actively at work as "employees" under the usual definition of that term, as used in connection with the Social Security program, and so that it does not include non-working disability pensioners.

Finally, as a long-time career civil servant, I am constrained to express my dismay that it has taken so long for HCFA to issue regulations on this subject (4½ years after enactment of the underlying legislation, during which time the procedure followed in this area has been most illogical, inconsistent, inequitable, and anti-social).

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